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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 09/07/16-09/09/16 and 09/12/16-09/14/16.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the walls, floors and ceilings in resident rooms, shared bathrooms, hallways, dining room, kitchen, and the kitchen's pantry were kept in good repair including peeling, detached, missing, and dangling ceiling covering, detached baseboards, missing or peeling paint, scuffed areas, cracks, open holes and creviced areas that could possibly serve as an entry point and harbor for pests. The findings are: Interview with the Operations Manager (OM) of the facility's contracted pest control provider on 09/12/16 at 09:15 a.m. revealed: -The pest control provider documented information for the facility which would "aid in the elimination of the pests" in the "Recommended Client Corrective Action" section on the Pest Prevention Service Reports (PPSRs). -On 07/01/16, the pest control provider was	D 074		

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onsite at the facility to inspect and treat only one room for bed bugs.
-The Pest Prevention Service Report (PPSR) dated 07/28/16, contained information on repairs recommended in specified areas to "aid in the elimination of the bed bugs" in "Recommended Client Corrective Action" section.

Review of the "Pest Prevention Job Agreement" dated 08/01/16 revealed "The customer further agrees to cooperate as needed to perform the pest prevention service and to correct conditions conducive to pest infestations as indicated on the service report."

Observation of resident room 215 on 09/07/16 at 11:00 a.m. revealed:
-There was a large yellowish tan stain on the ceiling approximately 2 feet by 1 foot in size to the left of the entrance room door.
-There was missing, dangling, popcorn ceiling material approximately one foot long that exposed the under layer of the ceiling located to the right of the residents bed.
-There were multiple (greater than 5) round areas of white caulking on the yellow painted wall.

Observation of the shared restroom for resident room 215 on 09/07/16 at 11:10 a.m. revealed:
-There was a large piece of popcorn ceiling material approximately 9 inches by 6 inches hanging loosely from the ceiling that exposed the under layer of the ceiling.
-There was a yellow stain approximately 1 foot by 1 foot unilateral to the exposed under layer ceiling material.
-The inside of the entrance door that lead to an adjacent resident room had multiple black scuff marks that covered the width of the door located approximately 2 feet from the floor.

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D 074	Continued From page 2 -The floor had black stained areas that circled the front of the toilet. Observation of resident room 208 on 09/07/16 at 11:15 a.m. revealed there were greater than 4 caulked white areas on the yellow colored painted walls approximately 3 feet from the floor. Interview with the Executive Director (ED) on 09/07/16 at 12:45 p.m. revealed: -The facility used an outside contract agency for maintenance needs. -The contracted maintenance staff came to the facility one to two times per week. -All facility repair needs were sent through by a computer based work order. -Some repair request needs could be done in paper form. -The ED would provide a copy of the work request orders. Observation of resident room 300 on 09/07/16 at 4:06 p.m. revealed: -There were 5 areas of peeling popcorn ceiling material around a rounded mechanism on the ceiling. -There were multiple white caulked round areas in a row type pattern, along the plaster like walls of the room. Observation of resident room 315 on 09/07/16 at 4:15 p.m. revealed: -There was a dangling piece of popcorn ceiling material approximately 3 inches long in the middle of the ceiling. - There were greater than 20 round holes, in a row type pattern, located approximately 2 feet from the floor on the plaster like walls of the room.	D 074		

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D 074	Continued From page 3 Observation in the activity room on 09/08/16 at 9:34 a.m. revealed: -There was a square wooden color speaker with blue and red coated electrical wires that were leading from the side of the speaker. -The color coated electrical wire ends had exposed copper colored wiring that were connected to a dangling metal box. -The metal box was dangling by 3 or more black coated electrical wires. -The black coated electrical wires were hanging outside of a recessed metal box inside of the wall located to the right of the entrance room door. -There was an open gap to the inner portion of the wall that surrounded the metal box positioned inside of the wall. Interview with the Activity Coordinator on 09/09/16 at 8:50 a.m. revealed she was not sure how long the wires had been exposed close to the speaker on the wall because she had never noticed it. Observation of the metal box and electrical wires close to the speaker in the activity room on 09/13/16 at 10:16 a.m. revealed the box had been secured in place or no longer visible and there was not an open area in the wall. Observation of resident room 308 on 09/09/16 at 6:34 a.m. revealed: -There was a section approximately 12 inches long by 6 inches long of popcorn ceiling material that had peeled from the ceiling, dangling down, over 2 resident chest of drawers in the room. -There was a section above the entrance door, approximately one inch from the wall with 2 bulged and thin cracked areas of popcorn ceiling material that was approximately 4 inches in length.	D 074		

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D 074	Continued From page 4 Observation of the 100 hallway ceiling on 09/09/16 at 6:42 a.m. revealed: -A section of the ceiling located around resident room 101 had popcorn ceiling material approximately 1 yard in length that was loose, sagging down and exposed the under layer of the ceiling. -Located close to a side exit door on the 100 hall, there was a 4 inch area of popcorn ceiling material peeled away from the ceiling surface that left a gap and crevice. Observation of resident room 104 on 09/09/16 at 6:57 a.m. revealed: -There was a long strip of detached and separated popcorn ceiling material that was approximately 6 feet in length that started at the ceiling light fixture and extended to the room's left long wall. -There was a section of the strip, approximately 2 feet in length and 3 inches in width that suspended from the ceilings surface material exposing the under layer of the ceiling wall. -There were several cracks and crevices in the exposed under layer of the ceiling. -There was a yellow circled patterned stain on the popcorn ceiling surface in a section of the detached strip. -There was a round area of missing popcorn ceiling material with creviced type boarders, approximately 3 inches by 4 inches on the other side of the detached strip. -There was a section of missing popcorn ceiling material that caused a creviced border approximately 6 inches in length located over the resident chest of drawers and bed. -There were scattered areas of missing paint on the walls ranging in size from approximately ½ inch by ½ inch to 2 inch by 1 inch -There were horizontal black colored scuff marks,	D 074		

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missing areas of paint and indented areas on the wall material at the head of the resident's bed located approximately 1 yard from the floor.

Interview with the resident assigned to resident room 104 at 09/09/16 at 6:57 am revealed:
-The ceiling had always been that way.
-The ceiling material had not fallen on his head yet but "it was going to".

Observation of resident room 109 on 09/09/16 at 7:04 a.m. revealed:
-Scattered throughout the ceiling, there was large sections of removed popcorn ceiling material which left a rough, uneven ceiling finish; and other sections of the ceiling had remaining, scattered, uneven portions of popcorn ceiling material.
-The left long wall, approximately 3 feet from the floor had an area greater than 12 inches long with peeled, missing paint that exposed a white and brown under layer color.

Interview with the resident assigned to room 109 on 09/09/16 at 7:05 a.m. revealed:
-The resident had lived at the facility about a year.
-The ceilings and walls were that way when he came.
-The area on the wall looks like the bed scrubbed across it.

Observation of resident room 107 on 09/09/16 at 7:22 a.m. revealed:
-There was a non-adhered section of the ceiling material that left an open separation to the ceilings finish located on the left side of the room and approximately 18 inches long.
-The closet door had a 1 to 1 ½ inch long hole located approximately 4 feet from the floor.
-The hole in the closet door caused an opening to

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the internal space of the door.
-A piece of tissue paper had been loosely stuffed inside of the hole in the closet door.

Observation of resident room 100 on 09/09/16 at 7:25 a.m. revealed:
-There was an approximate 1 ½ inch by ½ inch creviced hole in the bathroom door that exposed the under layer of the door.
- On one of the yellow colored room walls, there were 2 large white caulked areas and several smaller areas of white caulking along the walls.

Interview with the ED and the Regional Director of Operations on 09/09/16 at 8:05 a.m. revealed they would follow up with the concerns related to the wall and ceilings.

Interview with the ED on 09/09/16 at 11:45 a.m. revealed:
-Some of the damaged areas on the walls and ceilings in residents' rooms were possibly caused during the pest control provider's recent heat treatment for bed bugs.
-Staff members should report any areas that need repair.
-The ED does "walk through daily, but not in every room".
-The ED had reported the issues in room 104 to the contracted maintenance provider on their last visit a few months ago.
-The maintenance person assigned to the facility was on work leave due to an injury.
-A few months ago the maintenance person was in the process of scrapping the ceilings in room 109 but did not complete the work.
-The white caulked areas along the walls were treatment holes made during the bed bug treatments.
-The pest control provider was not responsible for

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D 074	Continued From page 7 repairing the treatment holes made in the walls. A second Interview with the ED on 09/09/16 at 11:55 a.m. revealed he was aware that insects could hide in cracks and crevices. Observation of room 205 on 09/12/16 at 10:50 a.m. revealed there was an area on the ceiling approximately 12 inches long to the left of the light fixture with a slight separation in the popcorn ceiling material that caused a crevice to the underside of the ceiling covering. Observation of resident room 206 on 09/12/16 at 12:05 p.m. revealed: -There was an area of separation of the popcorn material on the ceiling beside the light fixture that caused a slight crack in the ceiling's covering. -There were scattered cracked areas of the popcorn ceiling material located over the room's window. -There were small round white caulked areas in a row pattern along all of the walls except the cement wall. Observation of the shared resident restroom for resident room 211 on 09/12/16 at 12:09 p.m. revealed an area around a round device on the ceiling that had missing popcorn material which exposed the under layer portion of the ceiling and caused a slight crevice underneath the ceiling's covering. Observation of resident room 204 on 09/12/16 at 12:12 p.m. revealed: -There were greater than 20 holes at the same height on the wall that were approximately ½ inch to ½ inch in size on all walls of the room except the cemented wall.	D 074		

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D 074	Continued From page 8 Observation of the women's common bathroom on the 200 hall on 09/12/16 at 12:17 p.m. revealed: -On the left side of the ceiling close to the cement wall, there was a large yellow stained area on the popcorn ceiling that was approximately 2 feet by 1 foot long. -There were scattered small cracked and creviced areas within the yellow stained popcorn ceiling area. Observation of resident room 202 on 09/12/16 at 12:19 p.m. revealed the side panel of the door had scattered scuffed areas, with chipped paint and indented sections that exposed the underwood and a white under color. Observation of resident room 207 on 09/12/16 at 12:23 p.m. revealed: -Two of the room walls had greater than 10 small round holes approximately ½ inch by ½ inch in size, located at the same height, in a row pattern on 2 walls of the room. -There was a dark yellow stained area on the popcorn ceiling covering approximately one foot by ½ foot directly over one the resident's bed. Observation of the ceiling of the 200 hallway on 09/12/13 at 12:28 p.m. revealed a separation of the ceiling surface covering that caused a creviced opened area, located between resident room 203 and 205. Observation of resident room 203 on 09/12/16 at 12:32 p.m. revealed: -There were greater than 20 holes approximately ½ inch to ½ inch in size, at the same height, in a row pattern, along 3 walls of the room. -There was an area on the ceiling with bulging, and missing popcorn ceiling material.	D 074		

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-There was a separate area with a bulging, yellow stain with missing sections of popcorn ceiling material approximately 4 inches by 6 inches in size. The missing section caused a crevice and exposed the under layer of the ceiling.

Observation of resident room 201 on 09/12/16 at 12:36 p.m. revealed:
-There was a hole approximately the size of a golf ball in the wall located between 2 closets' approximately 3 feet from the floor with missing, cracked paint that exposed the inner portion of the wall.

Observation of resident room 308 on 09/12/16 at 3:04 p.m. revealed:
There was a small hole approximately ½ inch by ½ inch on the ceiling.
-The long wall to the right had greater than 8 small holes the size of a screw at different heights on the wall.
-On the outside side of the entrance door there was a small area of missing paint that exposed the under color of the door at the height of the door handle.

Observation of a shared resident restroom for room 310 on 09/12/16 at 3:11 p.m. revealed:
-The floor covering in the restroom had a dull finish and a black stain around the front and sides of the toilet.
-There was a drain in the middle of the restroom floor; the floor covering was cracked and not sealed around the drain and the floor covering lifted up when the edges were pushed against.
-The inside of the restroom door had missing paint in a horizontal pattern at the bottom fourth of the door.

Observation of a shared resident rest room for

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resident room 311 and 313 on 09/12/16 at 3:13 p.m. revealed there were several areas of missing paint and black scuff marks in a horizontal line across the bottom section of the inner door on both entrance doors.

Observation of resident room 309 on 09/12/16 at 3:24 p.m. revealed:
-There were 8 areas of cracked popcorn ceiling material located above the entrance door.
-There was a horizontal scuff mark with missing areas of yellow paint on the lower portion of the left wall.
-There were horizontal scuff marks on the lower half of the door.

Observation of a shared resident restroom for resident room 309 on 09/12/16 at 3:26 p.m. revealed there was an area on the right side of the hand sink with missing wall covering that exposed a rough, cardboard color material approximately 5 inches long by 3 inches wide.

Observation of resident room 307 on 09/12/16 at 3:36 p.m. revealed:
-There was a black cable cord hanging down from the ceiling against the upper half of the closet door and draped behind a strip on the wall.
-The wall underneath the heating and air unit had multiple areas of peeling paint and missing wall material exposing a cement type under layer.

Observation of the exterior side of the door to the bathing spa room on the 300 hall on 09/12/16 at 3:48 p.m. revealed there were areas of missing yellow paint in a horizontal line across half of the lower portion of the door.

Observation of the exterior doors on the 300 hall on 09/12/16 at 3:50 p.m. revealed there were

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greater than 5 resident doors that had horizontal scuff marks and missing paint along the bottom portion of the doors.

Observation of resident room 306 on 09/12/16 at 3:52 p.m. revealed:
-There was an area on the left side of the ceiling approximately 12 inches long and 8 inches wide with missing, dangling popcorn ceiling material.
-There were black horizontal scuff marks and missing paint on the lower portion of the entrance door on the inner side.

Observation of a shared restroom for room 306 on 09/12/16 at 3:53 p.m. revealed:
-The floor covering was dull with a large black stain in scattered sections of the floor.
-There wall was a cracked and indented area approximately 5 inches in length and 3 inches wide that exposed the under layer material of the wall beside the toilet.
-There was an entry door on the opposite side of the shared restroom that had scuff marks on the lower portion of the door.
-The entry door on the opposite side of the shared restroom had missing paint and black scuff marks with missing paint on the lower portion of the door facing.
-There was a black stained and cracked sealant around the bottom rim of the toilet.
-There were two holes that created an opening into the wall beside the towel dispenser that were approximately ½ inch by ½ inch in size.

Observation of resident room 304 on 09/12/16 at 4:23 p.m. revealed:
-The 1st closet door had a horizontal black scuff mark across the entire width of the door with areas of missing paint that exposed the wood under layer located under the door's handle.

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D 074	Continued From page 12 -The bottom of the door corner had an area approximately 15 inches long by 1 inch wide with splintered and missing wood material exposing the doors under layer. -The right side of the door facing around the 1st closet had an area of missing paint below the level of the closets handle. -The wall between two closets had a horizontal black scuff mark with a section of missing paint approximately 3 foot from the floor. -The wall between the two closets had a black scuff mark with missing paint approximately 5 inches from the floor. -The 2nd closet door had scattered black scuff marks and missing paint below the handle. -The 2nd closet door had an area of missing paint on the edge of the door just above the handle. -There was a 15 inch detached section of pliable baseboard, the back of the baseboard had pieces of wall material, and the wall where the baseboard had detached was uneven, crumbled and missing pieces of the wall material and cardboard colored material. -There was greater than 10 holes approximately ½ inch by ½ inch in size that caused an opening into the inner wall on 2 of the room walls. Observation of resident room 103 on 09/12/16 at 5:10 p.m. revealed: -There was an area of the ceiling with a large piece of missing, peeling and yellow stained popcorn ceiling material. -There was a section of the black pliable baseboard beside the resident's bed that was loose and not flush with the wall. One area of this section was lying flat on the floor in an area approximately 1 yard long. -Beside the air and heating system, there was a section of the baseboard rolled up in a circular pattern and lying against the side of a dresser.	D 074		

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D 074	Continued From page 13 -There was a split in the popcorn ceiling covering greater than 1 yard long. Observation of resident room 113 on 09/12/16 at 6:08 p.m. revealed: -The closets door on the side facing the closet had a large cracked, splintered open hole that covered half of the width of the door approximately one foot from the floor. Interview with the Memory Care Manager (MCM) on 09/13/16 at 10:00 a.m. revealed: -All repair requests were placed into a computer system that was sent to a contracted maintenance provider. -The facility had a maintenance sheet that staff members documented repair needs on, the maintenance sheet was turned in to the MCM or the ED. -If staff attempted to call a request in, they would be redirected to make the repair request through the computer system. - A verbal repair requests could be made face to face when the maintenance person was on site, however, this would depend on the person performing the repairs in the facility since all repairs should be routed through the computer system. -The MCM and the ED were unable to generate a repair history or pending repair request within the computer system. -It was the ED's responsibility to follow up with repairs that had been completed. -Maintenance personnel communicate with the ED. -There was a box designated for staff to place repair requests in. -The MCM did most of the repair requests. -No repair needs had been requested lately. -The MCM could not provide the past	D 074		

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maintenance repair sheets.
-The MCM thought there was only one contract maintenance repair worker assigned to the facility.
-The MCM understood the assigned contract maintenance worker for the facility had been out of work for an extended time but unsure how long.
-The contracted Maintenance staff were out at the facility randomly.
-The ceilings of the facility had been an issue for some time.
-The ceilings in the MCM's office and the 2nd or 3rd room on the men's hall had needed repairing as long as she had worked at the facility.
-The MCM did not know about the visible electrical wiring on the wall, in the activity room.

Interview with the Regional Director of Operations (RDO) on 09/13/16 at 10:55 a.m. revealed:
-The contracted maintenance provider would be onsite 09/14/16.
-The contracted maintenance provider was supposed to be at the facility 1.5 days per week.
-If there was an urgent repair need, staff were supposed to call "district".
-The RDO could not say he had received a call from the ED about the needed repairs.
-The RDO was "surprised" regarding the repair needs at the facility.

Interview with the staff member from the contracted maintenance provider on 09/14/16 at 8:05 a.m. revealed:
-One day a week he was dedicated to be at this facility however this depended on other work related needs and schedules at other sites.
-He could not state when the last weekly visit was made because he had been out of work for the past 2 weeks.

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-There were 5 work orders made for this building since July 2016.
-There was a work request made on 07/25/16 for a pipe leaking under the steam table.
-There was a work request made on 07/25/16 for the ceiling "coming down" in resident room 203.
-There was a work request made on 07/25/16 to repair a switch for a fan.
-There was a work request made on 07/25/16 to repair the ceiling in room 103.
-There was a work order made on 06/26/16 to have a file box put in the business manager's office.
-The work done in the facility was based on work orders only.
-The contract maintenance provider was not responsible to inspect repair needs at the facility but would bring any concerns seen while at the facility to their attention.
-The contract maintenance workers would only go into resident rooms if there was a work order.

Observation on the 300 hallway on 09/14/16 at 9:30 a.m. revealed the ED and the contracted maintenance staff member were rounding the facility looking at the walls, floors and ceilings.

Observation of a shared resident restroom for resident room 306 with the ED on 09/14/16 at 9:31 a.m. revealed the commode was loose from the base of the floor which caused the commode to wobble when touched.

Interview with the ED on 09/14/16 at 9:32 a.m. revealed:
-The ED would have repairs done to the commode in the shared resident restroom for resident room 306.
-The ED had noted the other repair needs for the floor, cracked indented walls, scuff marks on the

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door, and holes beside the towel dispenser in the shared resident restroom for room 306.

Observation of resident room 207 on 09/14/16 at 10:30 a.m. revealed there was an area of the popcorn ceiling material that was stained yellow, approximately 12 inches by 6 inches, located above resident bed B at the head portion of the bed.

Observation in resident room 308 on 09/14/16 at 11:44 a.m. revealed there were scattered areas of missing paint under the heating and air unit that exposed a grey color cemented layer of the wall.

Observation on the 300 hallway on 09/14/16 at 11:45 a.m. revealed there were greater than 9 exterior doors on the hallway with scuff marks and missing exterior paint or coating on the lower portions of the door.

Observation of the front dining room on 09/14/16 at 11:01 a.m. revealed:
-There were multiple areas of missing white paint along the mid wall molding.
-There was a piano against the end wall of the dining room, the wall had 2 holes approximately ½ inch by ½ inch in size that were approximately 23 inches apart.
-There was an area on the back wall in the first section of the dining room that had scuffed, chipped paint, there was a resident table in front of this area on the wall.

Observation of the front dining room on 09/14/16 at 11:22 a.m. revealed:
-The 3rd light from the 2nd entrance to the dining room had a section of the ceiling light cover that was missing, approximately 6 inches by 4 inches.
-On the right hand side of the 3rd light, the ceiling

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D 074	Continued From page 17 had greater than 10 yellow round stains. Observation of a floor door plate, at an exit door on the left side of the kitchen on 09/14/16 at 11:30 a.m. revealed: -The door plate was loose with missing screws and could be pushed out of place to the left or to the right. -There was a slight opening to the outside, under the bottom of the door and door plate when the door was in a closed position. Observation of the ceilings and walls in the kitchen and pantry on 09/14/16 at 11:31 a.m. revealed: -On a small wall, to the left of the kitchen entry door there were cracks and crevices where the wall and ceiling met. -The wall in the kitchen, to the right of the pantry door, under an exhaust fan, there were 2 small screw holes. -There was a section approximately 8 inches long behind the dishwasher that had peeling, dangling pieces of white paint. -There was a hole the size of a small screw on the wall behind a long sink. -There was an area of the ceiling at an electrical box in the pantry room approximately 6 inches long with missing popcorn ceiling material. -In the pantry room, there were 2 walls with cracked and creviced areas where the wall and ceiling met. Review of a pest report from the contracted pest control provider dated on 07/28/16 revealed: -There was documentation for a "crawling insect service". -The inspection had been done for 26 resident rooms, laundry, nurses' station, and hallways. -The "activity" was seen in outlets, on ceilings,	D 074		

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around fire detectors, headboards, mattresses, and behind pictures.
-There was documentation that there were major concerns for the cracks and crevices in the building.
-There was recommendations for corrective actions in resident rooms to repair holes, cracks, and gaps in or near ceiling as those could possibly serve as a harborage areas for pests.
-There was documentation that structural repairs were needed and no materials were applied.

Interview with the RDO on 09/14/16 at 11:57 a.m. revealed:
-The maintenance repair provider would come to do a walk though of the facility,
-There would be painting and repairs made to the cracks and crevices of the building.
-The detached baseboards in the resident's rooms could have occurred when the pest control provider was looking behind the baseboards while treating the rooms, but it should have been repaired.

Interview with the ED on 09/14/16 at 12:22 p.m. revealed:
-There would be an additional staff person from the contracted maintenance provider at the facility to focus on the areas of painting and repairing the cracks and crevices,
-The threshold at the kitchen's exit door will be repaired and all other cracks and creviced areas in the kitchen and pantry.

Interview with the RDO on 09/14/16 at 4:19 p.m. revealed the painting of the building was planned prior to the survey and was supposed to have occurred this week but was delayed

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D 074	Continued From page 19 Review of the Plan of Protection submitted by the facility dated 09/14/16 revealed: -The ED would complete a walk through the facility with the contracted maintenance provider to make a list of all rooms that needs repairs/addressed. -Painting staff from the contracted maintenance provider would be on site beginning 09/14/16 to start repairs and would remain onsite until all identified areas were addressed. -The ED or MCM would perform weekly rounds to identify any additional areas that need to be addressed. -If areas are identified, the ED or MCM would enter a work order into the contracted maintenance provider's work order system. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2016.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility	D 079		

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failed to maintain an environment free of hazards and obstructions as evidenced by failing to repair an uncovered electrical outlet beside a resident's bed who was oxygen dependent, resulting in the oxygen machine being plugged in to an electrical outlet in the common 200 hallway, creating a trip/fall hazard; failing to enclose an electrical outlet and light switch left in an unoccupied empty resident room (#209); failing to enclose electrical wiring approximately 6 feet high on the wall next to the entrance door in the activity room; and storing 4 unused televisions on the floor in the television room on the 300 hall.

The findings are:

Observation of resident room 209 on 09/07/16 at 11:50 a.m. revealed:
-The room door was closed but not locked.
-The electrical light switch for the room located approximately 3 feet from the floor had no cover plate exposing the internal metal bracket and electrical wiring.
-There was an electrical outlet approximately 3 feet from the floor with no cover plate exposing the internal metal bracket and the electrical wiring.

Interview with the Executive Director (ED) on 09/07/16 at 5:40 p.m. revealed:
-Resident room 209 had been treated for bed bug infestation.
-The cover plates had been removed to provide pest treatment in the room.
-He would have the cover plates replaced over the outlet and light switch.

Observation of resident room 209 on 09/12/16 at 12:16 p.m. revealed the light switch, electrical outlet and the cable outlet plates had been

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D 079	Continued From page 21 replaced and secured in place. Observation on the 200 hall on 09/07/16 at 3:55 p.m. revealed: -There were two electric cords leading from the side of the door way of resident room 201. -The two cords were laying on the hallway floor along the wall and plugged into a nearby electrical outlet in the hallway. -There was a handrail on the wall above the outlet and cords on the floor. Observation of resident room 201 on 09/07/16 at 3:56 p.m. was unsuccessful due to personal care being provided for the resident. Interview with a Personal Care Aide (PCA) on 09/07/16 at 3:58 p.m. revealed: -The cords were coming from the resident's oxygen concentrator and hospital bed. -The cords had been like that for about a month. -The PCA thought the outlet in the resident's room was "messed up". -Maintenance had been working on the outlet beside the resident's bed. -No residents had tripped on the electric cords in the hallway that she knew of. Observation of resident room 201 on 09/07/16 at 4:30 p.m. revealed: -There was a sign posted on the wall, above an oxygen concentrator that advised not to push the residents bed to the wall, outlet may fall back out and cause a fire. -The oxygen concentrator was positioned between the room's entrance door and directly beside the head of the hospital bed. -The uncovered electrical outlet was approximately 1-2 feet from the floor on the right wall on the other side of the bed.	D 079		

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D 079	Continued From page 22 -The uncovered electrical outlet was not visible until the covers on the residents bed was pushed away from the wall. -The uncovered electrical outlet was hanging out of the wall and attached to the walls electrical wiring. -The uncovered electrical outlet was hanging out of the wall causing the plug in section to face down toward the floor. -The uncovered outlet's electrical wiring and one red screw nut (cap) was positioned upward. Interview with a Medication Aide (MA) on 09/07/16 at 4:30 p.m. revealed: -The MA was not certain how long the electrical outlet had not worked. -The electrical outlet had been "clipped" (capped) off, no more than 4 months. -The resident's bed would move up and down, and would scrub against the outlet, causing the outlet to fall back out of the wall. -The oxygen supplier suggested to place a sign up beside the residents bed to caution staff about the outlet and fire risk. -The PCA's placed the sign up. -The sign beside the resident's bed had been up since the beginning of the summer. Observation of resident room 201 on 09/07/16 at 4:55 p.m. revealed the ED was in the room working on the uncovered electrical outlet. Interview with the ED on 09/07/16 at 4:56 p.m. revealed: -Resident #2 does not have a roommate. -The ED would switch Resident #2's hospital bed to the opposite side of the resident bedroom since there was a working electrical outlet to power the electric hospital bed and the oxygen concentrator.	D 079		

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A second Interview with the ED on 09/07/16 at 5:40 p.m. revealed:
-The cord in the hallway was a trip hazard; "it's no excuse."
-The ED had asked staff to switch Resident #2's bed to the other side of the room.
-The staff members had not moved Resident #2's bed, so he moved the bed today (09/07/16) himself.
-The electrical wire was capped off.

Telephone interview with staff of DHSR Construction section on 09/08/16 at 9:03 a.m. revealed:
-All cover outlets that were not secured should be replaced.
-If an outlet was "not properly terminated" it could be a potential hazard.

Confidential staff interview revealed:
-There was something wrong with the outlet beside Resident #2's bed.
-The outlet beside Resident #2's bed had not worked for about 1 ½ months.
-The outlet in the hall way had to be used for Resident #2's oxygen and hospital bed.
-She had never been told to rearrange Resident #2's bed to the other side of the room because of the outlet.
-Resident #2's bed always stayed 4 inches away from the wall because of the outlet.
-She was not sure what was wrong with the outlet beside Resident #2's bed.

Telephone Interview with a family member on 09/08/16 at 5:10 p.m. revealed:
-The "caution sign" had been on the wall for the last 3 to 4 months.
-The sign and the possibility of a fire hazard was

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a concern to the family member.
-Resident #2 actually read the sign to the family member during one visit.
-The family member did discuss the issue with the ED.
-During one of the family member's visits, another resident unplugged the cords in the hallway.
-The family member did not think it was a good idea to use the plugs in the hallway for the oxygen and the bed.

Observation in the television room on the 300 hall on 09/07/16 at 11:27 a.m. revealed:
-There were 4 unused televisions, 2 were sitting on the floor and 2 were on the floor stacked on top of each other.
-There was one television cord laying on the floor in a curved position in front of one of the televisions.

Observation on 09/07/16 at 4:10 p.m. revealed the televisions were still setting on the floor in the television room on 300 hall.

Interview with the ED on 09/07/16 at 5:05p.m. revealed he would make sure the televisions were moved today.

Observation in the activity room on 09/08/16 at 9:34 a.m. revealed:
-There was a square wooden color speaker with blue and red coated electrical wires that were leading from the side of the speaker.
-The color coated electrical wire ends had exposed copper colored wiring that were connected to a dangling metal box.
-The metal box was dangling by 3 or more black coated electrical wires.
-The black coated electrical wires were hanging outside of a recessed metal box inside of the wall

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D 079	Continued From page 25 located to the right of the entrance room door. -There was an open gap to the inner portion of the wall that surrounded the metal box positioned inside of the wall. Interview with the Activity Coordinator on 09/09/16 at 8:50 a.m. revealed she was not sure how long the wires had been exposed close to the speaker on the wall because she had never noticed it. Observation of the square wooden speaker and electrical wires in the activity room on 09/13/16 at 10:16 a.m. revealed the blue and red coated electrical wires leading from the speaker, copper colored wiring connected to a dangling metal box and black coated electrical wires located to the right of the entrance room door had been secured in place or no longer visible and there was not an open area in the wall. _____ Review of the Plan of Protection submitted by the facility dated 09/09/16 revealed: -The facility removed the bed from the wall where the outlet needed repair. -The plugs were relocated from the hallway into another location within the room. -In the future, the ED would assure maintenance tasks were followed-up and completed. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2016.	D 079		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff	D 206		

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D 206	Continued From page 26 The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure housekeeping duties performed by the Personal Care Aides (PCAs) between the hours on 7:00am and 9:00pm were limited to non-routine tasks as evidenced by PCA staff completing resident's laundry on a scheduled, routine basis between 7:00am and 9:00pm. The findings are: Observation on 09/07/16 at 4:01pm revealed there was a PCA taking a stack of laundry into a resident's room. Observation on 09/09/16 at 07:40am revealed a PCA came in to the laundry room to check on laundry that was being laundered Observations throughout the remainder of the survey revealed various staff on first and second shift were observed completing laundry duties such as removing laundry from residents' rooms, washing laundry/drying laundry, and returning laundry to residents' rooms. Confidential staff interview revealed:	D 206		

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-The PCAs did the laundry on all three shifts.
-It was hard get everything done and still get the laundry done too.
-There was extra work because of the bed bug problem (more laundry).

Confidential interview with a second staff revealed:
-The PCAs were responsible for doing each resident's laundry that was showered on the shift.
-Third shift was supposed to wash linen and bedspreads.

Confidential interview with a third staff revealed:
-The PCAs did laundry every shift.
-It "has always been like that."
-Completing laundry tasks took staff off of the floor at times.
-Staff were needed on the floor to provide resident care.
-The laundry got "backed up" sometimes because there were not enough people working; staff's first concern had to be resident care.

Confidential interview with a fourth staff revealed there had been times when residents' laundry was not done due to short staffing.

Review of the "Laundry List Sign In Sheet" revealed there was documentation of residents' laundry being completed on 09/01/16-09/4/16, 09/06/16, 09/08/16, 09/09/16, and 09/12/16 between the hours of 07:00am-09:00pm.

Interview with a resident on 09/13/16 at 3:08pm revealed:
-The staff helped the resident take a shower on Monday, Wednesday, and Friday.
-The staff laundered the resident's clothes on the same day the resident was showered.

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D 206	Continued From page 28 Interview with a second resident on 09/14/16 at 09:40am revealed: -The resident was upset because she had not had her laundry returned after it was removed "last week." -The resident's clothing had been missing since she was moved to another room (on 09/09/16)`because of the bed bug activity. -The resident wanted her dark colored slacks and satin pillowcases. -The resident was getting tired of wearing the same clothes over and over again. -The resident only had one gown in her drawer and it was not hers. -"The Boss" (Executive Director) told the resident her clothing would be returned "Friday" (09/09/16) but the clothing had not been returned yet. Interview with the Memory Care Manager (MCM) on 09/13/16 at 4:35pm revealed: -Laundry was supposed to be done on all three shifts. -Each resident's laundry was done on the day of their shower. -Linens were changed three times weekly and as needed when soiled. -The PCA for the shift who bathed the resident was responsible for laundering the residents clothing and linens. -The MCM was not aware staff were not supposed to complete routine housekeeping duties during the hours of 7:00am and 9:00pm. Interview with the ED on 09/09/16 at 07:30am revealed: -"Everybody" was responsible for laundry. -Laundry was done on all three shifts by "floor staff."	D 206		

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to meet the assessed personal care needs of 5 of 7 residents sampled (#1, #6, #7, #9, #10) as related to showering, dressing, and shaving. The findings are: Confidential interview with a staff revealed: -There were times when there was not enough staff working, but staff made sure the residents were dry and were bathed whenever they could. -"We do the best we can." Confidential interview with a second staff revealed: -There had been times when residents' personal care was "lacking" due to short staffing. -Sometimes there was not even one personal care staff scheduled for each of the three halls. -The MCM told staff to "do what you can." Confidential interview with a third staff revealed: -There were some times when residents were not showered because the resident refused.	D 269		

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-There were some times when residents were not showered because there was not enough staff.
-Staff were supposed to document personal care and refusals on the ADL sheet in the computer.

Confidential interview with a fourth staff revealed:
-Two (named) residents who were supposed to be bathed on 2nd shift say they don' t get showered because there was not enough staff.
-"One day last week" the 2nd shift Medication Aide (MA) (named) said "we' re only doing showers for the ones who can tell their families;" three (named) residents would be showered but the other residents would not be showered.

Confidential interview with a family member revealed:
-The family visited the facility weekly during 1st shift.
-There were usually 4 or 5 staff on duty when the family visited.
-The family found their loved one smelling of urine or feces when they visited but the resident' s linen and clothing "looked clean."
-The resident had bad breath and did not receive oral care.

Confidential interview with a second family member revealed:
-The resident of the family member did not receive the assistance from staff needed for showering; the resident was left alone in the shower.
-There was not enough staff on duty sometimes for the resident to receive a shower.
-Within the last month, the family member had visited and observed the resident' s bed had been made up but it was wet with urine.
-When the family visited, the family noticed the resident' s roommate (who is incontinent) smelled

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like stool and had lay there in the stool without staff checking on him for over one hour.

Confidential interview with a third family member revealed:
-When the family visited the resident, the resident had not been bathed, "especially on Saturdays."
-The resident was "often" unshaved.

1. Review of Resident #7's current FL-2 dated 01/20/16 revealed:
-Diagnoses included Alzheimer's dementia, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and osteoarthritis.
-Resident #7 required assistance with bathing and dressing.

Observation and interview with Resident #7 on 09/07/16 at 11:33am revealed:
-Resident #7 walked into his room with the use of a rollator walker; Resident #7 had a steady gait.
-Resident #7 was wearing a tan jacket which was zipped all the way up.
-Resident #7 was unshaved.
-Resident #7 said "I like this place right here. They work hard and are nice to me."
-Resident #7' s only complaint was he could not get shaved enough.

Review of the Memory Care Shower schedule revealed Resident #7 was scheduled to be bathed/showered on 2nd shift on Tuesday, Thursday, and Saturday.

Review of Resident #7's computer generated "ADL (Activities of Daily Living) Log" for September 2016 revealed:
-There was an entry for shaving "staff physical assists with shaving, staff does more than

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resident."
-There were staff initials documenting Resident #7 was shaved on 09/06/16.

Observation of Resident #7 on 09/09/16 at 06:31am revealed:
-Resident #7 was sitting in a chair in the quiet room.
-Resident #7 was unshaved and had hair on his face that was more than a five o' clock shadow/stubble.

Review of Resident #7's September 2016 "ADL Log" revealed there were staff initials documenting Resident #7 was shaved on 09/08/16.

Refer to the interview with the Memory Care Manager (MCM) on 09/09/16 at 1:28pm.

Refer to the interview with the MCM on 09/13/16 at 4:35pm.

Refer to the interview with the primary care provider (PCP) contracted by the facility on 09/14/16 at 12:07pm.

Refer to the interview with the Executive Director (ED) on 09/14/16 at 12:25pm.

2. Review of Resident #6's current FL-2 dated 04/06/16 revealed:
-Diagnoses included Alzheimer' s disease, hypertension, and hyperlipidemia.
-Resident #6 was intermittently disoriented.
-Resident #6 required assistance with bathing and dressing.

A. Review of Resident #6's current assessment and care plan dated 02/07/16 revealed:

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D 269	Continued From page 33 -Resident #6 was intermittently disoriented. -Resident #6 required "limited" assistance with bathing his upper body and "extensive" with bathing his lower body. -Resident #6 required "limited" assistance with dressing. -Resident #6's bathing schedule was Monday, Wednesday, and Friday on 2nd shift. Observation and interview of Resident #6 on 09/07/16 at 10:54am revealed: -Resident #6 was standing in the hallway near the nurses' station. -Resident #6 was neatly groomed and was wearing a burgundy colored long sleeve knit shirt with a light gray shirt underneath the burgundy shirt and black pants. -Resident #6 smiled when spoken to. -Resident #6 did not know what kind of assistance he received from staff but staff treated him "good." Observation and interview of Resident #6 on 09/08/16 at 5:38pm revealed: -Resident #6 was walking in the hallway near the dining room. -Resident #6 was wearing the same clothes he was wearing on 09/07/16. Observation of Resident #6 on 09/09/16 at 6:03am revealed Resident #6 was dressed in the same clothing he was wearing on 09/07/16 and 09/08/16. Confidential staff interview 09/09/16 (time withheld to maintain confidentiality) revealed Resident had been wearing the same clothes since "Wednesday morning" (09/07/16). Observation and interview of Resident #6 on	D 269		

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09/09/16 at 9:00am revealed:
-Resident #6 had on the same clothing he was observed wearing earlier that day (09/09/16) and on 09/07/16, and 09/08/16.
-Resident #6 did not know the last time he changed his clothes.
-When asked if staff assisted him with dressing, Resident #6 responded "yes."
-When asked if staff assisted him with showering, Resident #6 responded "yes."

Observation of Resident #6 on 09/09/16 at 11:40am revealed:
-Resident #6 had changed clothes.
-Resident #6 had on tan colored pants and a light blue and white striped button front short sleeved shirt.

Interview with the MCM on 09/09/16 at 1:28pm revealed:
-The MCM noticed that day (09/09/16) Resident #6 had on the same clothes for 3 days.
-Resident #6 was supposed to be showered every Monday, Wednesday, and Friday on 2nd shift.
-"Sometimes" Resident #6 refused bathing and wore extra layers of clothes.
-Refusals were supposed to be documented by the Medication Aides (MAs) in the "care notes" in the "Quick Mar."

Interview with the MCM on 09/13/16 at 4:35pm revealed:
-On 09/09/16, the MCM asked staff on 1st shift to shower Resident #6 and change his clothes; the staff said it was not their job because Resident #6 was supposed to be showered on 2nd shift.
-The MCM told the staff to "do it anyway."
-Staff had assured Resident #6 had been bathed and had his clothing changed on 09/09/16 after

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the MCM brought it to the staff's attention.
-When the MCM had asked staff why Resident #6 had been wearing the same clothes for 3 days, staff told the MCM Resident #6 had refused his bath.
-There was no documentation on the Quick Mar that Resident #6 refused his bath.

Review of Resident #6's computer generated "ADL Log" for September 2016 revealed:
-There were staff initials documenting Resident #6 was bathed on 09/02/16, 09/05/16, 09/07/16, and 09/09/16.
-There was not any documentation that Resident #6 refused showering on any date in September 2016.
-There was a computer generated entry for "dressing: Donning... staff adjusts clothes. Staff guides arms and legs into clothing (resident can left arms/legs/hands). Staff guides feet into shoes."
-There were staff initials documenting Resident #6 was assisted with "dressing: donning" on first, second, and third shift from 09/01/16-09/09/16.
-There was a computer generated entry for "dressing: helping... staff assists to complete buttons/fastens clothing. Staff completes fastening buttons...Resident does more than staff."
-There were staff initials documenting Resident #6 was assisted with "dressing: helping" on first, second, and third shift from 09/01/16-09/09/16.
-There was a computer generated entry for "dressing: removing... staff guides arms or legs out of clothing (resident can lift arms/legs/hands)..."
-There were staff initials documenting Resident #6 was assisted with "dressing: removing" on first, second, and third shift from 09/01/16-09/09/16.

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D 269	Continued From page 36 Telephone interview with Resident #6's family on 09/08/16 at 12:05pm revealed: -Resident #6 was clean and his clothes looked clean when the family visited him. -The only problem the family observed was the smell of urine on the men' s hall, but it was resolved after the family brought it to the facility' s attention. Refer to the interview with the the MCM on 09/13/16 at 4:35pm. Refer to the interview with the PCP contracted by the facility on 09/14/16 at 12:07pm. Refer to the interview with the ED on 09/14/16 at 12:25pm. B. Observation of Resident #6 on 09/09/16 at 6:03am revealed: -Resident #6 was scratching the left side of his neck and his upper chest. -Resident #6 had 10 superficial round spots on his upper chest wall; two of the spots were red and measured 0.5 cm x 0.5 cm in diameter. -None of the spots were draining. Interview with Resident #6 on 09/09/16 at 06:03am revealed: -Resident #6' s chest had "been like that a long time." -The spots itched. Interview with the MCM on 09/13/16 at 4:35pm revealed: -The "rash" on Resident #6' s chest had never been reported to her prior to 09/09/16. -There had not been any skin assessment done to address the skin on Resident #6's chest prior	D 269		

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to "Friday" (09/09/16).
-The MCM went and assessed the chest and notified the physician.
-The contracted PCP's office had been to the facility to evaluate Resident #6 and wrote a prescription to treat the areas on his chest.

Review of a Physician Visit form for Resident #6 dated 09/12/16 revealed:
-"Several open areas on chest that are itching and open."
-There was a medication order for hydrocortisone cream 1% apply to areas on chest twice daily until healed.
-The order/visit form was signed by a Nurse Practitioner.

Refer to the interview with the MCM on 09/09/16 at 1:28pm.

Refer to the interview with the PCP contracted by the facility on 09/14/16 at 12:07pm.

Refer to the interview with the ED on 09/14/16 at 12:25pm.

4. Observation and interview of Resident #1 on 09/07/16 at 4:15pm revealed:
-Resident #1 was in the 300 hallway near the dining room.
-Resident#1 was neatly groomed and had on a skirt.
-Resident #1's right leg had red whelps and 2 round red spots about the same size as a mosquito bite below the knee.
-Resident #1's left leg had 3 or 4 round, red spots that were about the same size as a mosquito bite below the knee.
-Resident #1 scratched her right leg.
-"I love these people but I need help with my leg,

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it itches."

Interview with the MCM on 09/07/16 at 4:22pm revealed the MCM would assess Resident #1's legs "now."

Observation on 09/07/16 at 4:28pm revealed the MCM assessed Resident #1's legs.

Confidential staff interview revealed:
-The staff observed "bite marks" on Resident #1's neck on "Tuesday" (09/08/16).
-The staff had not had time to complete a skin assessment 09/08/16 because the facility was short staffed.
-The staff could not recall whether the bites were reported or the staff forgot to report them.

Review of Resident #1's record revealed:
-There was no documentation in the record about Resident #1's legs.
-There was no skin assessment dated for 09/08/16 for Resident #1.

Confidential interview with four staff revealed:
-Skin assessments were supposed to be done when personal care was being provided to the residents.
-Whenever a resident had a changes in their skin, the PCA was supposed to document the skin assessment on the skin assessment sheets.
-The PCA gave the skin assessments to the MAs; the MAs notified the physician and MCM.
-The skin assessment sheets were filed in each resident's record after being reviewed by the MCM.

Interview with the MCM on 09/09/16 at 1:28pm revealed:
-The MCM did not complete a skin assessment

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for Resident #1 on 09/07/16.
-The MCM acknowledged a skin assessment had not been completed by staff for Resident #1 on 09/08/16 either.

Telephone interview with Resident #1's guardian on 09/08/16 at 4:30pm revealed:
-Resident #1 was intermittently disoriented.
-The guardian had last visited Resident #1 on Tuesday, 09/08/16, and did not see any problems with her neck or legs, but Resident #1 had been wearing panty hose that day (09/08/16).
-When the guardian visited Resident #1, she was usually clean.

A telephone message left on the Registered Nurse's voicemail at Resident #1's physician's office on 09/08/16 at 4:55pm was not returned.

Refer to the interview with the MCM on 09/09/16 at 1:28pm.

Refer to the interview with the ED on 09/14/16 at 12:25pm.

5. Review of Resident #9's current FL-2 dated 08/31/16 revealed diagnoses included vascular dementia, cerebrovascular accident (CVA), and right sided hemiplegia.

Review of Resident #9's assessment and care plan dated 06/16/16 revealed:
-Resident #9 was intermittently disoriented; "forgetful-needs reminders."
-Resident #9 required "limited" assistance with bathing.
-Resident #9's bathing schedule was Tuesday, Thursday, and Saturday on first shift.
-Resident #9 required "limited" assistance with dressing.

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D 269	Continued From page 40 Observation of Resident #9 on 09/12/16 at 12:38pm revealed: -Resident #9 was walking on 300 hall (using a rollator walker) towards the front desk. -Resident #9 had on a light pink shirt with black letters/writing on it, a black long sleeved shirt underneath the pink shirt, and green pants. -Resident #9' s pink shirt had stains on the chest area. Observation of Resident #9 on 09/13/16 at 08:16am revealed: -Resident #9 was sitting at a table in the dining room. -Resident #9 was wearing the same light pink shirt with black writing that she had been wearing on 09/12/16. Observation and interview with Resident #9 on 09/13/16 at 2:38pm revealed: -Resident #9 was wearing the same soiled light pink shirt with food stains and writing which read "great grandmothers are important too," a black long-sleeved shirt underneath the light pink shirt, and green pants that she was observed to be wearing on 09/12/16 and earlier on 09/13/16. -Resident #9 did not receive a bath today and did not know why, maybe because there was not enough workers. -People (staff) do not show up for work here sometimes. Observation of Resident #9 on 09/13/16 at 4:30pm revealed: -Resident #9 was walking on 300 hall using her rollator walker. -Resident #9 was wearing the same clothing (soiled light pink shirt) as she was wearing 09/12/16 and earlier on 09/13/16.	D 269		

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D 269	Continued From page 41 Review of the Memory Care Shower list revealed Resident #9 was scheduled to be showered on Tuesday, Thursday, and Saturday on 1st shift. Review of Resident #9"s computer generated "ADL Log" for September 2016 printed on 09/14/16 revealed there were staff initials documenting Resident #9' s bathing was completed on 09/01/16, 09/03/16, 09/06/16, 09/08/16, 09/10/16, and 09/13/16. Observation and interview with Resident #9 on 09/14/16 at 10:26am revealed: -Resident #9 had on different/clean clothes. -Resident #9 bathed herself "last night" using "paper towels." -Resident #9 "had to do something" because she had missed her shower. Refer to the interview with the MCM on 09/09/16 at 1:28pm. Refer to the interview with the MCM on 0913/15 at 4:35pm. Refer to the interview with the PCP contracted by the facility on 09/14/16 at 12:07pm. Refer to the interview with the ED on 09/14/16 at 12:25pm. 5. Review of Resident #10's current FL-2 dated 08/31/16 revealed: -Diagnoses included dementia/Alzheimer's, hypothyroidism, and chronic hypertension. -Resident #10 required assistance with bathing and dressing. Observation of Resident #10 on 09/12/16	D 269		

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revealed:
Resident #10 was walking in the 200 hall.
-Resident #10 was wearing black knit pants and a long sleeved shirt with a fictional character printed on it.

Review the Memory Care Shower schedule revealed Resident #10 was schedule for bathing on Tuesday, Thursday, and Saturday on 1st shift.

Observation of Resident #10 on 09/13/16 at 07:40am revealed Resident #10 was sitting in the quiet room and had on the same clothing she was observed to be wearing on 09/12/16.

Observation of Resident#10 on 09/14/16 at 08:05am revealed:
-Resident #10 walked out of the rest room on 200 hall with a staff member and into the dining room.
-Resident #10 had on the same clothing she was observed to be wearing on 09/12/16 and 09/13/16.
-Resident #10' s hair was greasy and uncombed.

Observation of Resident #10 on 09/14/16 at 11:08am revealed:
-Resident #10 was on the 300 hall near the dining room.
-Resident #10 was wearing the same fictional character shirt and black pants she was observed wearing on 09/12/16 and 09/13/16.
-Resident #10 smelled of body odor and her hair was greasy.

Interview with Resident #10 on 09/14/16 at 11:08am revealed:
-Resident #10 was oriented to self only and was unable to answer questions about bathing or dressing.
-Resident #10 asked "am I supposed to be with

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D 269	Continued From page 43 you? " Review of Resident #10's "ADL Log" for September 2016 printed on 09/14/16 revealed: -There were staff initials documenting Resident #10 was last bathed on 09/09/16. -There was an entry for hair care: "staff assist resident to shampoo hair, dry and complete task, Staff does more than resident." -There were staff initials documenting that Resident #10's hair was shampooed daily from 09/01/16-09/11/16 and 09/13/16. Telephone interview with Resident #10's family on 09/14/16 at 11:08am member revealed the family member was overall satisfied with Resident #10's personal care. Refer to the interview with the MCM on 09/09/16 at 1:28pm. Refer to the interview with the MCM on 0913/15 at 4:35pm. Refer to the interview with the PCP contracted by the facility on 09/14/16 at 12:07pm. Refer to the interview with the ED on 09/14/16 at 12:25pm. _____ Interview with the MCM on 09/09/16 at 1:28pm revealed: -Staff were supposed to complete skin assessments whenever "anything out of the ordinary" was first noticed. -The staff observing the skin concern was responsible for completing the assessment. -The MCM reviewed the skin assessment forms in the bucket list folder and then the Medication Aides were supposed to file the assessments in	D 269		

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D 269	Continued From page 44 the resident's record. -All staff were supposed to follow the skin assessment policy. -When a resident refused care, the refusals were supposed to be documented by the Medication Aides (MAs) in the "care notes" in the "Quick Mar." Interview with the MCM on 09/13/16 at 4:35pm revealed: -If residents' personal care was not completed on the assigned shift due to staffing, the MCM expected the residents' care to be completed on the next shift. -Staff should be documenting care and refusals in Quick MAR. Interview with the PCP contracted by the facility on 09/14/16 at 12:07pm revealed: -The PCP expected all residents to receive the assistance and care in accordance with their care plan. -There were potential health concerns if residents were not kept clean or had good hygiene. Interview with the ED on 09/14/16 at 12:25pm revealed the ED expected residents to receive care according to their care plan.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 45 Based on observations, record reviews, and interviews, the facility failed to notify the primary care provider (PCP) for 1 of 6 residents sampled (#6) of a resident's itching, scratching, and open areas on the resident's upper chest. The findings are: Review of Resident #6's current FL-2 dated 04/06/16 revealed: -Diagnoses included Alzheimers disease, hypertension, and hyperlipidemia. -Resident #6 was intermittently disoriented. Observation and interview of Resident #6 on 09/07/16 revealed: -Resident #6 was standing in the hallway near the nurses' station. -Resident #6 smiled when spoken to. -Resident #6 did not know what kind of assistance he received from staff but staff treated him "good." -Resident #6 was observed scratching his upper chest through his clothing. -A staff member directed Resident #6 into the Memory Care Managers (MCM) office to be evaluated by the PCP. -Resident #6 went into the MCM office with the staff member. Observation of Resident #6 on 09/09/16 at 6:03am revealed: -Resident #6 was dressed in the same clothing he was wearing on 09/07/16 and 09/08/16. -Resident #6 was scratching the left side of his neck and his upper chest. -Resident #6 had 10 superficial round spots on his upper chest wall; two of the spots were red and measured 0.5cm x 0.5cm in diameter. -None of the spots were draining.	D 273		

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Interview with Resident #6 on 09/09/16 at 06:03am revealed:
-Resident #6's chest had "been like that a long time."
-The spots itched.

Confidential staff interview revealed:
-The staff observed Resident #6 with bed bug bites on his arms and chest in June 2016 and had bites "now."
-The bites had gotten some "better."

Confidential telephone interview with a former staff revealed:
-The facility had bed bugs.
-Resident #6 had bed bug bites on his chest.
-Resident #6 wore multiple layers of clothing to prevent himself from being bitten.

Telephone interview with Resident #6's family member on 09/08/16 at 12:05pm revealed:
-Resident #6 liked living in the facility.
-Overall, the staff took good care of Resident #6.
-Resident #6 had not complained to the family member about any skin problems.

Interview with the MCM on 09/09/16 at 1:28pm revealed:
-The MCM had never observed Resident #6 to have any bites or scratching.
-The MCM had never been notified about the skin on Resident #6's upper chest or complaints of itching "until now" (time of the interview).
-If the MCM had known about Resident #6's skin, she would have addressed it.

Telephone interview with Resident #6's primary care provider (PCP) contracted by the facility on 09/12/16 at 6:45pm revealed:

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-The PCP had not been notified about the skin on Resident #6's chest wall.
-The PCP had called the facility on the morning of 09/09/16 and spoke with the MCM to inquire about Resident #6 and other residents (after her office was contacted by the survey team on 09/08/16).
-The MCM "assured" the PCP that Resident #6 was at his baseline and did not have any skin "lesions".
-The PCP last evaluated Resident #6 on 09/07/16.
-Staff did not tell the PCP about Resident #6 itching or "lesions" on his chest wall.
-Staff told the PCP Resident #6 was at his "baseline."
-The PCP expected to be notified about Resident #6's itching/skin.

Interview with the MCM on 09/13/16 at 4:35pm revealed:
-The "rash" on Resident #6's chest had never been reported to the PCP prior to 09/09/16.
-There had not been any skin assessment done to address the skin on Resident #6's chest prior to "Friday" (09/09/16).
-Resident #6 was seen by the PCP "last Wednesday" (09/07/16) but staff did not report the areas on his chest to the physician.
-The MCM did not know why staff did not report the areas on Resident #6's chest on 09/07/16.
-The MCM assessed Resident #6's chest and notified the physician.
-The contracted PCP's office had been to the facility to evaluate Resident #6 and wrote a prescription to treat the areas on his chest.

Review of a Physician Visit form for Resident #6 dated 09/12/16 revealed:
-"Several open areas on chest that are itching

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D 273	Continued From page 48 and open." -There was a medication order for hydrocortisone cream 1% apply to areas on chest twice daily until healed. -The order/visit form was signed by a Nurse Practitioner.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the food preparation, storage and serving areas for the facility were free from contamination related to an infestation of roaches. The findings are: Observations during the kitchen tour on 09/09/16 at 5:15 a.m. revealed: -When the lights of the kitchen were turned on, roaches were seen crawling. -There was 4 live roaches crawling on the open walkway spaces of the kitchen floor. -There were 2 live roaches crawling under the steam table in the kitchen. -There were 2 live roaches that crawled out behind a sign on the kitchen wall. -There were 6 live roaches under the air	D 282		

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conditioner vent in the kitchen.
-There were 4 live roaches crawling on the floor, under a 3 section compartment sink in the kitchen.
-There were 3 dead roaches under the 3 section compartment sink in the kitchen.
-There were 2 dead roaches on the floor, under the defrost sink in the kitchen.
-There was one large dead roach under the disinfectant on the kitchen wall.
-The roaches varied from small to large in size and light brown to a dark brown in color.

Observation during the dining room tour on 09/09/16 at 5:25 a.m. revealed:
-There were 2 live roaches crawling on the floor in the back dining room underneath an air conditioner vent.

Confidential interview with 6 staff revealed:
-The facility had an "ongoing" problem with roaches for "months and months".
-The facility had "always" had a roach infestation; "it's ridiculous. "
-The Executive Director (ED) and Memory Care Manager (MCM) were aware of the roach infestation.
-Staff observed roaches in the hallways, resident rooms, and dining room.
-There had been roaches in the facility as long as the staff person could remember.
-One staff last observed a roach in the facility dining room one month ago.
-A second staff last observed a roach in the dining room "last week".
-A third staff had not seen any roaches in "awhile"; most roaches had been seen in the kitchen, "they like those areas. "

Review of the Pest Prevention Service Reports

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(PPSRs) from the contracted pest control provider related to pest control treatment for roaches revealed:
-There was documentation of regular pest prevention services being completed in areas of the facility including but not limited to the dining room, dry storage, and kitchen on 12/28/15, 01/28/16, 03/04/16, 04/22/16, 05/06/16, 06/17/16, and 07/01/16 .
-On the PPSRs dated 12/28/15, 01/28/16, 04/22/16, 06/17/16, and 07/01/16, there was documentation in the "recommended client corrective actions" section to repair baseboards, holes, cracks, and gaps in the kitchen; "these serve as entry points for pests." No pests found.
-On the PPSR dated 03/04/16, there was documentation "in the recommended client corrective actions" section to repair base boards, holes, cracks and gaps in the kitchen; "these serve as entry points for pests." In the"date complete" box , there were handwritten initials. No pests were found.

Interview with a staff of the contracted pest control provider on 09/09/16 at 08:38am revealed the pest control provider would expect to be notified if staff were observing roaches in the facility.
A second interview with a staff of the contracted pest control provider on 09/09/16 at 08:45am revealed the pest control provider thought the facility may have more than one type of roach infestation in the kitchen and dining room areas.

Review of the PPSR dated 09/09/16 revealed:
-"Medium" German cockroach activity was found in the kitchen.
-"Light" smoky brown cockroach activity was found in the dining room.
-The pest control provider completed regular pest

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prevention service on 09/09/16, treating the kitchen and dining room for cockroaches.
-A follow up service was scheduled for 09/16/16.

Interview with the Operations Manager (OM) for the facility's contracted pest control provider on 09/12/16 at 09:15am revealed:
-The contracted pest control provider treated the kitchen and dining room of the facility on a monthly basis for pests such as roaches.
-The pest control provider had a toll free telephone number for the facility to notify the pest control provider of any "concerns."
-The pest control provider documented information for the facility which would "aid in the elimination of the pests" in the "recommended client corrective actions" section on the PPSRs.
-The pest control provider would expect the facility to complete the recommended repairs.

Interview with the ED on 09/12/16 at 12:20pm revealed the ED initialed the PPSR dated 03/04/16 to indicate the repairs recommended in the kitchen in the "recommended client corrective actions" section of the PPSR had been completed.

Confidential staff interview revealed the staff had never observed any repairs being completed in the kitchen.

Review of the "Pest Prevention Service Agreement" dated 05/11/15 revealed "...the client further agrees to cooperate as needed to perform the pest prevention service and correct conditions conducive pest infestations as indicated on the service report."

Interview with a staff member on 09/08/16 at 1:30 p.m. revealed:

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D 282	Continued From page 52 -The facility had a bad roach problem a while back. -The staff member had seen roaches in the kitchen and dining areas crawling on the floor and walls. -The staff member thought the roach problem was "bad, but not as bad as in the past". Interview with a staff member on 09/08/16 at 7:00 p.m. revealed: -The roaches were bad in the kitchen. -The staff member had noticed the roaches in the kitchen when the staff member would go to the kitchen at night to get ice for the residents. -The staff member saw roaches after the kitchen was "shut down, and the lights were out", the roaches would be "running everywhere when the lights were turned on". -The staff member informed the shift manager about the roaches. Interview with the ED on 09/09/16 at 11:55 a.m. revealed: -The ED was not aware of the current roach activity in the kitchen. -The ED expected the Dietary Manager to "keep up with it" and report any roaches seen. -If the roaches had been reported to him he would have inspected the area and would have notified the pest control provider. _____ Review of the Plan of Protection submitted by the facility dated 09/09/16 revealed: -The contracted pest control provider was immediately dispatched and performed treatment in the identified areas. -Preventative treatment was performed in surrounding areas inside and outside of the community.	D 282		

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D 282	Continued From page 53 -Dietary staff would perform visual inspections and remove pests "one the spot" prior to meal preparation and service times. -The contracted pest control provider would return to the facility weekly until there were no more active sightings. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2016.	D 282		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 1 of 2 residents sampled (#4) who had a history of wandering in to other residents' rooms was protected from physical harm by another resident (#3) who was known not to like wandering residents in his room resulting in Resident #4 sustaining a hip fracture after being pushed by Resident #4; to investigate a families member's concerns for one resident (#4) with injuries of unknown origin such as scratches, bruises, and a knot on the head; to follow their established protocol for 2 of 2 residents sampled when bed bug activity was confirmed in one resident's room (#8) and bed bug bites were found on another resident (#11) to include notifying their contracted	D 338		

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pest control provider of bed bug activity and training all staff on the established protocol to follow for bed bug activity.

The findings are:

1. Review of Resident #4's current FL-2 dated 09/03/16 revealed:
-Diagnoses included Alzheimer's, muscle weakness, and moderate protein calorie malnutrition.
-Resident #4 was constantly disoriented.

Review of the Resident Register revealed Resident #4 was admitted to the facility on 01/22/16.

Confidential staff interviews revealed:
-Resident #4 was constantly disoriented, wandered, and required frequent redirection.
-Prior to his hip fracture (08/11/16, Resident #4 was able to walk and was known to walk around the facility "constantly."

A. Telephone interview with Resident #4's Power of Attorney (POA)/family member on 09/08/16 at 5:40pm revealed:
-Resident #4 moved in to the facility in January 2016.
-Resident #4 was "never" himself due to his diagnosis of Alzheimer's.
-The POA had some "concerns" about the facility; since being admitted to the facility, Resident #4 had "several injuries," 5 or 6 falls, and 3 or 4 hospitalizations.
-Resident #4 fell and broke his hip in 08/11/16.

Interview with a Medication Aide (MA) on 09/07/16 at 11:07am revealed Resident #4 had not been in the facility since 08/11/16 because he

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fell and broke his hip, requiring rehabilitation.

Review of the electronic "Charting Notes" for Resident #4 dated 09/08/16 at 2:52pm revealed:
-Resident #4 returned to the facility from rehabilitation.
-Resident #4 was "unable to walk and is in a wheelchair."

Observation of Resident #4 on 09/08/16 at 2:50pm revealed:
-Resident #4 was sitting in a wheelchair near the front desk.
-Resident #4 was neatly dressed/groomed.
-Resident #4 was alert and oriented to self only.
-Resident #4 did not respond when spoken to.
-Resident #4 was talking to himself.

Observation of Resident #4 on 09/09/16 at 06:00am revealed:
-Resident #4 was sitting in his wheelchair on the 100 hall.
-Resident #4 was singing and did not respond when spoken to.

Interview with the Memory Care Manager (MCM) on 09/13/16 at 4:35pm revealed:
-Resident #4 was "never oriented," wandered, and went in to other residents' rooms when he could walk.
-Resident #4 would walk down the halls often talking to himself and looking for his "kitty" (prior to fracturing his hip on 08/11/16).
-Resident #4 "may have aggravated" other residents by going into their rooms.
-Resident #4 "means no harm to anyone."

Confidential interview revealed:
-On 08/11/16, around lunch time, one of the facility staff and Resident #3 "were hollering."

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D 338	Continued From page 56 -Resident #4 hollered after the staff and Resident #3 hollered (on 08/11/16). -The staff said Resident #3 pushed Resident #4 down. -Resident #3 "shoved" Resident #4 and Resident #4 fell. -Resident #4 was sent to the emergency room (ER) for a broken hip. Confidential staff interview revealed: -There was an incident on 08/11/16, when Resident #4 was found on his buttocks on the floor in between Resident #3's room and his (Resident #4's) room on 100 hall. -Resident #4 had been moved from his normal room to the room located beside Resident #3's due to the bed bug activity/treatment. -The MCM and another staff (who no longer worked at the facility) responded to the incident. -Resident #4 went to the ER and had a fractured hip. -The staff was on duty on 08/11/16. -The staff did not see the incident but "heard" Resident #4 had been pushed down by Resident #3. -The staff had not observed any resident to resident aggression. Confidential interview with a second staff revealed: -Resident #3 did not like other residents to come in his room. -When/if "walkers" stopped at Resident #3's door or went in his room, Resident #3 "yelled" for them to "get out." -Resident #3 could become jittery and anxious at times when others got around him. -The staff heard incidents when Resident #3 was "loud" and telling Resident #4 to "get out." -When the staff "ran to see what was going on",	D 338		

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the staff had observed Resident #3 "push" Resident #4 out of his room a "couple times." (The staff was not sure of the dates).

Confidential interview with a third staff revealed:
-A "few weeks ago, maybe" Resident #3 "got upset" and "yelled" at a female resident because the resident walked by his room.
-The staff redirected the female resident away from Resident #3's room.

Interview with a resident on 09/14/16 11:20am revealed:
-Resident #4 went in Resident #3's room "and acted like it was his."
-"[Resident #3's name] did push [Resident #4's name] that one time because he would not leave."
-Resident #3 "closed the door" and Resident #4 "never came back."

Review of Resident #3's current FL-2 dated 08/03/16 revealed diagnoses included Alzheimer's dementia, Asperger's Syndrome, tardive dyskinesia, and coronary artery disease.

Review of Resident #3's assessment and care plan dated 08/02/16 revealed:
-Resident #3 was sometimes disoriented.
-Resident #3 was forgetful, "needs reminders."

Interview with Resident #3 on 09/12/16 at 5:55 p.m. revealed:
-The resident had been in the hospital for a urinary tract infection recently but reported he was back at his "baseline" now.
-The resident liked living at the facility but it was a "locked down unit."

Confidential staff interviews revealed:

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D 338	Continued From page 58 -Resident #3 was usually oriented. -The only time Resident #3 was ever observed to be disoriented was before he was sent to the ER for a urinary tract infection. -Resident #3 was alert and knew what was going on for the most part. -Resident #3 could perform most of his personal care independently. Interview with Resident #3 on 09/13/16 at 3:10pm revealed: -Resident #4 was a "regular torment" in Resident #3's "apartment" before he had his accident (on 08/11/16 when he fractured his hip) and had to get a wheelchair. -Resident #4 wandered in to Resident #3's room "at all hours." -Staff "don't do much to stop him (Resident #4)." -The last time Resident #4 wandered into Resident #3's room was about "one month ago." -Resident #3 "slammed the door" on Resident #4 "to try to get him out of here." (Resident #3 did not know the date he slammed the door on Resident #4. -"Then he (Resident #4) was gone for two to three weeks after that date and then returned back (to the facility), but now he's in a wheelchair." Interview with the MCM on 09/13/16 at 4:35pm revealed: -Resident #3 was oriented all the time. -On 08/11/16, the MCM was in her office when she heard a commotion and a resident "hollering help." -The MCM found Resident #4 with his back leaned up against the wall just past the TV room, near the end of 100 hall. -Another resident was there with Resident #4 trying to help him get up.	D 338		

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-Resident #4 was saying "ow, ow" and rubbing his hip.
-Resident #4 was sent out to the ER.
-An incident report was done.
-The MCM "thinks one time "Resident #3 "reached out and hit" Resident #4.
-The MCM was "not really sure" of the date of the incident.
-The MCM did not know if an incident report was completed for the incident.
-When Resident #3 saw Resident #4 in the hallway near Resident #3's room, Resident #3 would get loud.
-Staff would hear Resident #3 speaking loud and go down to redirect Resident #4.

Review of the Incident Report dated 08/11/16 revealed:
-Resident #4 was found on the floor on 100 hall.
-Resident #4 was sent to the hospital emergency department (ED).

Based on observations, record reviews, and interviews, Resident #4 was not interviewable.

Review of the hospital "Discharge Summary" records dated 08/17/16 revealed:
-Resident #4 was admitted to the hospital on 08/11/16 and discharged on 08/17/16.
-Resident #4 was admitted after a "fall with left hip fracture."

Interview with the Executive Director (ED) on 09/13/16 at 3:05pm revealed:
-The ED was not sure how Resident #4 fell or broke his hip; the ED "had a lot going on then."
-The ED would provide a copy of the "report."

Interview with the ED on 09/14/16 at 12:25pm revealed:

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D 338	Continued From page 60 -"There were a few staff saying" Resident #3 "abused" Resident #4. -The Activity Director (AD) and an "Aide" said Resident #3 pushed Resident #4 on 08/03/16 and Resident #4 fell, "or it could be when he (Resident #4) fell on 08/11/16." -The ED heard the AD saying to other staff that Resident #3 pushed Resident #4 and Resident #4 fell (the ED could not recall the date). -The ED told the AD "not to say things that were not true" because the incident happened on a Saturday and the AD does not work on Saturdays. After reviewing the calendar, the ED acknowledged 08/11/16 was on a Thursday. -It was reported to the ED at a "stand up" (daily staff meeting) that Resident #3 closed the door on Resident #4 (the ED did not know the date of the stand up meeting/report). -Resident #3 "doesn't have a track record of abusing other residents." -The ED had reviewed the incident reports dated 08/03/16 and 08/11/16 and saw no reason to investigate based on the details documented on the incident reports. -It was reported to the ED at a "stand up" (daily staff meeting) that Resident #3 closed the door on Resident #4 "a couple months ago" (the ED did not know the date of the stand up meeting/report). -After receiving report that Resident #3 closed the door on Resident #4, the ED did not see any reason to conduct an investigation because the ED was not aware of any other incidents involving Resident #3 and Resident #4. -Other residents had closed the door on Resident #4 too. -The ED expected staff to re-direct, calm the residents, attempt to diffuse the situation, and separate the residents when incidents or behaviors took place.	D 338		

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-The facility had not implemented any additional safety interventions after Resident #3 closed the door on Resident #4.

Interview with the ED and MCM on 09/14/16 at 2:00pm revealed:
-Staff re-directed Resident #4 when he went in to other residents' rooms.
-The facility had not implemented any additional monitoring or other interventions to keep Resident #3 from harming Resident #4 or other residents.
-The facility had not increased supervision or implemented other interventions to prevent Resident #4 from wandering in to Resident #3's room.
-Resident #4 had "a right to walk."
-The incident reports had been done; nothing else needed to be done.
-The MCM "witnessed" Resident #4's fall on 08/11/16.
-Resident #3 was not around Resident #4 when he fell on 08/11/16; Resident #3's room door was closed.
-"There was nothing to investigate."

Review of the electronic "Charting Notes" for Resident #4 dated 08/11/16 at 6:54pm revealed:
-"Late note for today-around 1:00pm, MCM came out of my office and heard someone down A hall yelling out help." (A hall is 100 hall).
-'When I looked down the hallway," Resident #4 was "laying on the floor at the end of the hallway."
-"I got to him and checked him out and he was complaining of his upper left top leg hurting when I touched it. '
-The electronic charting note was documented by the MCM.

Refer to the interview with the facility's contracted

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primary care provider (PCP) on 09/14/16 at 12:07pm.

Refer to the "Resident Handbook and House Rules."

B. Telephone interview with Resident #4's Power of Attorney (POA)/family member on 09/08/16 at 5:40pm revealed:
-The POA was concerned because Resident #4 had red and purple colored bruises on his arms above his wrists, scratches on his arms and "various places," lost part of a nail "at some point," and had a "big knot" on his head; the POA could not recall the dates of the injuries.
-The POA had never observed any staff treat any resident "inappropriately"
-The POA wondered if Resident #4 was being abused.
-The POA called the ED to discuss his concerns sometime between 08/03/16 and 08/11/16 when Resident #4 broke his hip. (The POA could not recall the exact date but was sure of the time frame because Resident #4 fell on 08/03/16 and fell again on 08/11/16).
-The POA asked the ED to conduct an investigation for abuse.
-After the POA called the ED, a Medication Aide (MA) called the POA and "said nobody touched him." (The POA did not know the MA's name, but it was the same MA who reported Resident #4's fall on 08/03/16).
-The POA was "surprised" the MA called him; the MA sounded "defensive" to the POA.
-The POA did not know why the MA called him.
-The POA was unsure if an investigation was ever conducted because the ED never contacted the POA back.
-The POA was not aware of any interventions implemented by the facility to address Resident

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#4's injuries or falls.

A second telephone interview with Resident #4's POA on 09/14/16 at 2:19pm revealed:
-Resident #4 was being injured "frequently" and the POA was "concerned."
-In February or March 2016, the POA came to visit and noticed Resident #4 had a "knot" the size of a golf ball to the size of a lemon on his forehead.
-The POA asked staff what happened; staff did not know happened or where the knot came from.
-The POA asked to see the ED or MCM and was told both were not there (it was a weekend).
-The POA called the MCM the following Monday to inquire about the knot on Resident #4's forehead.
-The MCM told the POA Resident #4 was walking through a door and another resident closed the door on him and he hit his head.
-The POA thought the MCM said the incident had occurred the previous Thursday.
-The POA was not contacted about the incident and Resident #4 was not sent to the hospital.
-The MCM told the POA she was not aware he was not notified.
The POA asked the MCM why Resident #4 was not sent to the hospital; the MCM told the POA staff felt like Resident #4 did not need to go to the hospital.
-The POA had "genuine concern" and was not "accusing" any specific person of abusing Resident #4.
-The POA called the ED because the POA wanted the ED to look to see if anyone was abusing Resident #4.
-The ED told the POA "he would check in to it."
-The POA "expected him to talk to staff and look in to it" and call him back.
-The POA did not ask the ED to call him back, but

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"assumed" the ED would call him back.
-The ED never called the POA back.
-The POA depended on staff of the facility to take care of Resident #4.
-The POA did not know how the ED would know if Resident #4 was being abused if the ED did not check on it.

Confidential staff interview revealed the staff observed bruises on Resident #4's upper arms 1-2 months ago.

Confidential interview with a second staff revealed the staff observed bruising on Resident #4's forearms "a while before he broke his hip."

Confidential interview with a third staff revealed:
-Resident #4 had skin tears on his wrists at one time.
-The staff did not know the date when Resident #4 had skin tears.
-Resident #4 had thin skin.

Interview with the MCM on 09/13/16 at 4:35pm revealed:
-Resident #4 had bruising on his hip after having a fall (the MCM did not know the date).
-Resident #4 bruised easily.

Review of the electronic "Charting Notes" dated between 06/24/16- 09/13/16 provided by the facility for Resident #4 revealed:
07/01/16: "Resident was walking in the hall when a staff member noticed he was bleeding on his hand ..."
07/21/16: "While changing resident, aide noticed scratches and bruising on resident [sic] left arm ..."
07/28/16: Orders were received for dressing for Resident #4's left thumb nail."Nail will eventually

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come off."
-There was no documentation of a knot on Resident #4's head in the electronic Care Notes during the dates of the electronic notes provided.

Review of the handwritten Care Notes in Resident #4's record revealed there was no documentation of about the knot on Resident #4's forehead or other injuries.

Interview with the Executive Director (ED) on 09/14/16 at 12:25pm revealed:
Resident #4 had some unexplained bruises within the past 3-4 months; the ED thought the bruises were on Resident #4's arms.
-The ED did not know if Resident #4's physician was notified of the bruises or if an incident report was completed.
-The ED would ask the MCM if Resident #4's physician was notified and an incident report was done; if so, the ED would provide a copy of the documentation.
-Resident #4's family member called the ED "within the last 3 months" because he was "concerned" because Resident #4 "walked everywhere and other residents got upset."
-The family member "wanted to know if he (Resident #4) was ok."

Confidential staff interviews revealed:
-Resident #3's behavior had not ever been discussed with the staff.
-Staff were not aware of any investigations being conducted regarding Resident #4 being abused.
-Staff had not been asked by management about the incidents when Resident #4 was pushed by other residents.
-Staff had not been asked about the incident when Resident #3 closed the door on Resident #4.

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D 338	Continued From page 66 Based on observations, record reviews, and interviews, Resident #4 was not interviewable. Interview with the ED and MCM on 09/14/16 at 2:00pm revealed the ED had not investigated whether Resident #4 was being abused even after Resident #4's POA called and requested an investigation. Documentation related to Resident #3's behaviors, Resident #4's head and other injuries, documentation from staff meetings, the policy on resident to resident abuse, or any other pertinent documentation was requested from the ED and MCM at various times throughout the survey; however there was no additional documentation provided. Refer to the interview with the facility's contracted primary care provider (PCP) on 09/14/16 at 12:07pm. Interview with the facility's contracted primary care provider (PCP) on 09/14/16 at 12:07pm revealed: -The PCP did not recall ever being notified of Resident #4 being injured by another resident. -The PCP did not recall ever being notified of any resident with "abusive" behaviors towards other residents. Review of the "Resident Handbook and House Rules" revealed "The harmful touching of another person is prohibited. Any assault by a Resident is subject to immediate discharge of the Resident." 2. Observations, record reviews, and interviews revealed the facility had an active bed bug problem and had been previously treated for bed	D 338		

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bugs multiple times. The facility did not have a written procedure or policy for bed bug activity; however, the facility did have an established corporate protocol which was supposed to be implemented and followed for bed bug activity.

Interview with the ED and Memory Care Manager (MCM) on 09/07/16 at 12:49pm revealed:
-When bed bugs activity was found, the protocol was for staff to notify the ED or MCM, remove the resident from the room, bathe the resident, check the resident's skin, change the resident's clothing, clean the room, launder the clothing and linen using the dry-wash-dry method, and notify the contracted pest control provider.
-All staff were aware of the protocol that was to be followed.

Interview with the Regional Director of Operations (RDO) on 09/09/16 at 11:05am revealed:
-There was no corporate written policy for bed bugs but there was an established corporate protocol for bed bugs.
-The corporate protocol had been "effective" when implemented; the facility had implemented the protocol.
-The protocol to be followed if bed bug activity was found was as follows: staff were supposed to notify the ED or MCM, strip the bed linen and launder the linen and resident's clothing using the dry-wash-dry method, wash the resident, move the resident out of the room, clean the room, and notify the contracted pest control provider by telephone.
-The contracted pest control provider usually responded to the facility within 24-48 hours.
-If residents were observed to have bites, a skin assessment and incident report should be completed.
-The ED was supposed to sign the incident

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reports.
-The ED was responsible for assuring the bed bug protocol was followed; if the ED was not there, the MCM was responsible for assuring the protocol was followed.
-The RDO expected the protocol to be followed whenever bed bug activity was observed.

Interview with a staff member on 09/07/16 at 10:50am revealed:
-The facility "had a bed bug issue" all over the facility, on all halls, two weeks ago.
-21 resident rooms had been treated with a heat chamber; heat killed the bed bugs.

Confidential interview with a resident revealed:
-Bed bugs had been on the resident's bed "so bad" but the resident could not remember when.
-The bed bugs were little black bugs a little bigger than an ant.

Interview with a second resident revealed:
-When asked if the resident had observed any bugs in their room, the resident stated "in the corner" and pointed to the bottom left corner of the bed.
-The resident denied having any bites.

Interview with a third resident revealed:
-The resident had seen bugs in their bed.
-The resident described the bugs as "little bugs" and "brown bugs."
-The resident did not know when the bugs were seen.

Confidential interview with a resident's family member revealed:
-The family observed bed bugs on the resident's clothing 1 to 2 months ago.
-The resident had bed bug bites on two different

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D 338	Continued From page 69 occasions 1 to 2 months ago. Interview with the Executive Director (ED) on 09/07/16 at 12:30pm revealed: -Over a period of time, the facility had a reoccurring problem with bed bugs. -The problem was addressed by having the facility treated for bed bugs with three different types of treatment: two kinds of heat treatment and also with a spray treatment used to kill the bugs. -The facility did not have bed bugs now. -The facility was treated for bed bugs in March 2016 and 08/19/16 through 09/01/16 by a contracted pest control provider; a form of heat treatment was used by the pest control provider. -Between the treatments in March 2016 and August 2016, "staff said they thought they saw bed bugs." -A resident's family member thought she saw bed bugs in the resident's room and reported the observation to staff (the ED could not recall the date the family reported seeing the bed bugs or which staff it was reported to). -Bed bugs were confirmed in the resident's room; the room was treated with the new heat treatment by the contracted pest control provider. -The ED had been "proactive" by having the bed bug dogs come to the facility to check for bed bug activity. -The last treatment (August 2016) used a different form of heart treatment than the previous type of heat treatment (March 2016). -In August 2016, the pest control provider "cooked the entire room this time" which involved the pest provider setting up equipment to heat the entire room being treated. -During the previous treatment, items were moved to and placed inside of a heat chamber but the entire rooms were not heat treated.	D 338		

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D 338	Continued From page 70 A. Confidential staff interviews on first, second, and third shifts revealed: -The facility was "infested" with bed bugs. -The facility had bed bugs for "at least a year." -The facility treated for bed bugs "but it did not work." -In September 2015, bed bugs were found in four resident rooms; the four rooms were not treated with heat at that time. -The bed bugs got worse and were in 23 different resident rooms; "it got out of hand." -Interventions used by the facility to treat the bedbugs prior to the last heat treatment in August 2016 included a spray that staff could use, "but it doesn't work." -The ED "kept blowing it off" and "sweeping it under the rug" until a resident's family member taped a cup of bed bugs to the ED's office door. -Prior to the August 2016 treatment, bed bugs had been observed crawling on the doors to the residents' rooms, ceilings, residents' beds, and on the hallway walls and floors on all three shifts. -The bed bugs "were very visible." -When staff would pull back the sheets on residents' beds, bed bugs would be "crawling everywhere." -The bed bugs were worst on 3rd shift because "bed bugs come out at night." -Staff went in to residents' rooms "as little as possible" for fear of taking bed bugs home. -Family members were not informed about the bed bug infestations at the facility. -The ED and MCM did not want family members to know about the bed bug problem. -"They were afraid if they treated or notified families they would remove their loved ones from the facility." -The ED did not want families to know about the bed bugs so the facility would remain full and	D 338		

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families would not move residents out of the facility; "it's all about the money."
-Some families wanted to know what was going on and staff did not know what to tell the families.
-The MCM told staff at a staff meeting not to tell residents' families about the bed bug infestation.
-"We got chewed out with possibility for termination for talking to families about it" (bed bugs).
-Staff "has begged" the ED and MCM to do something about the bed bugs.
-"It's not fair to the residents."
-"It's sad. These people should not be living like this."
-Since to the last treatment in August 2016, the bed bug problem had "improved."
-"The bed bugs are still here."

Interview with a resident revealed:
-The resident saw a bed bug in her room yesterday (09/08/16).
-The resident's roommate killed the bed bug.

Interview with the ED on 09/07/16 at 12:30pm revealed:
-"Last week" (the week of 08/29/16) the housekeeper was vacuuming and "found 1 or 2" bed bugs on the headboards of residents' bed on the "300 hall."
-The headboards were removed from the beds, the beds were sprayed with a spray obtained from the contracted pest control provider, the bed linen was changed and laundered using the dry-wash-dry method, the "entire surface area" of the rooms were vacuumed, and the vacuum bag was taken to the dumpster immediately.
-To prevent infestation, the facility had implemented a new procedure after the last bed bug heat treatment: family could not bring in furniture for residents, all clothing brought in had

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to be laundered using the dry-wash-dry method, and all electronic equipment would have to be inspected before being brought in to the facility.

Observation during a facility tour on 09/07/16 at 4:40pm revealed:
-In room #208, there were bed bug droppings along the right edge of the mattress near the bottom/ foot area of the mattress.
-In room 209, there were bed bug droppings on the edges of the mattress on the right side near the wood headboard.

Confidential staff interview revealed Room 208 had bed bugs so bad "they were coming out of the sockets" (electrical outlets).

Observation and interview with the ED on 09/07/16 at 5:40pm revealed:
-The bed bug droppings found during the facility tour earlier that day (09/07/16) in rooms 208 and 209.
-The ED told the surveyors the bed bug droppings were not from current bed bug activity; the droppings were from previous bed bug activity.
-The facility used a contracted provider for pest control.
-The contracted pest control provider came to the facility every two weeks to do normal pest prevention treatment for ants, roaches and spiders.
-If any bed bugs were seen in the facility, staff were supposed to contact the pest control provider.
-The ED would obtain a copy of the facility's pest contract from the Regional Director of Operations.

Confidential staff interview revealed:

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-"Yesterday" (date and time with held to maintain confidentiality) the housekeeper had pulled a live bed bug off of a (named) resident.
-The MCM was aware of the bed bug found on the resident.

Confidential interview with a second staff revealed a housekeeper came in to lunch room "today" (date and time withheld to maintain confidentiality) and showed a staff a resident's bed sheet which contained bed bugs.

Confidential interview with a third staff revealed:
-"Yesterday" (date and time withheld to maintain confidentiality) the staff observed the housekeeper report seeing a live bed bug to the ED at the front desk.
-A live bed bug had been found that day (date and time withheld to maintain confidentiality) in room 300; the ED was aware of the observation.
-The staff did not know if the Regional Director of Operations (RDO) was aware of the bed bug observed in room 300.

Interview with housekeeping staff on 09/08/16 at 11:00am revealed:
-The housekeeper had not seen any bed bugs in the facility after the last bed bug treatment which took place in August 2016.
-After the last heat treatment in August 2016, the mattresses were cleaned "thoroughly."
-The housekeeper had a flashlight that she used to check for bed bugs as she cleaned and vacuumed.
-The housekeeper had not seen anything on any mattress after the last treatment and cleaning.
-"Any new residue" found on the mattresses "would most likely be from new bed bug activity."

Interview with the ED and RDO on 09/08/16 at

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D 338	Continued From page 74 6:55pm revealed: -The contracted pest control provider came as needed to treat for bed bugs. -As a preventive measure, the facility also had a contracted maintenance provider that provided services including having trained dogs come to the facility every 6 months to check for bed bug activity. -Any time bed bug treatment was performed by the contracted pest control provider, a separate contract outside of the basic pest contract was required. -The ED had not informed the RDO of the bed bug droppings in rooms 208 and 209 on 09/07/16. -The ED thought there was "no need" for the ED to notify the RDO because it was prior bed bug activity. -The RDO would assure rooms brought to his attention (208, 209, 213, 101, and 300) were checked for bed bug activity as soon as possible by the contracted pest control provider. Observation during a third shift facility tour 09/09/16 at 05:15am revealed: -There was a live round, dark brown bug, resembling a tick, which was later identified by staff of the facility's contracted pest control provider as a bed bug, in Room 311. -There was a dead, dark brown, round, bug with a flat body, which was later identified by staff of the facility's contracted pest control provider as a bed bug, in Room 300 -There was a dead black bug, which was later identified by staff of the facility's contracted pest control provider as a bed bug, on the wall over the door to room 101. Interview with the ED and MCM on 09/09/16 at 08:24am revealed:	D 338		

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-Staff had not informed them of any bed bug activity in the building since the start of the survey on 09/07/16.
-The ED and MCM did not know why information was received from multiple staff interviews that the facility had current bed bug activity was shared because staff never notified them.

Interview and observation with the RDO on 09/09/16 at 08:30am revealed:
-Staff notified the MCM that morning (09/09/16) of bed bug activity.
-Staff gave the MCM a list of where the bed bugs had been seen (the RDO referred to a list written on a sticky note he had in his hand).
-The rooms identified in the note to the MCM would be inspected by the pest control provider that day (09/09/16).

Interview with staff of the facility's contracted pest control provider during the pest control provider's inspection of the rooms on 09/09/16 at 08:38am revealed:
-The pest control provider came out to the facility on a monthly basis for "routine pest" treatment.
-The pest control provider did not treat for bed bugs during the monthly routine pest treatment and did not routinely check for bed bugs every time they were in the facility.
-Bed bugs were not covered under the normal pest contract.
-If the pest control provider observed bed bug activity during the monthly service/treatment, the pest control provider would notify the ED.
-The pest control provider staff would expect to be notified when bed bugs were observed by staff or residents.

Interview with the Operations Manager (OM) for the facility'scontracted pest control provider on

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D 338	Continued From page 76 09/12/16 at 09:15am revealed: -The contracted pest control provider finished treating 21 rooms for bed bugs on 08/19/16. -If the facility was seeing live bed buds after the treatment completed 08/19/16, the pest control provider would expect to be notified by the facility, especially with the facility's history of bed bug activity. -Since the last treatment for bed bugs was finished (August 2016), the OM did not recall any notification from the facility of any bed bug activity until "late last week." Interview with the RDO on 09/09/16 at 11:05am revealed: -During the contracted pest control provider's inspection of seven resident rooms on 09/09/16, current bed bug activity had been found each of the following rooms occupied by residents: room 300, 302, and 311. One live bed bug had been found in each of the three rooms (300, 302, and 311). -The facility would have the three rooms treated using a heat method. -The standard bed bug protocol would be followed to address the bed bug activity that was found on 09/09/16. -The RDO was first notified of bed bugs in the facility in room 300 in December 2015; the room had been treated on and off since December 2015. -After the dogs alerted them on the multiple rooms with bed bug activity (07/27/16), the contracted pest control provider made a proposal and corporate responded "within one week." -The cost of the treatment had not been an issue once the bed bugs had been identified in so many areas. Interview with the ED on 09/09/16 at 11:58am	D 338		

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revealed:
-Staff had been seeing "1 or 2" bed bugs in July 2016.
-The ED inspected the rooms and sprayed for bed bugs; the rooms were cleaned and linens were laundered using the dry-wash-dry method.
-Two families complained to the ED about bed bugs in July 2016.
-The ED did not have explanation why there were so many visible bed bugs on 07/28/16 but there were no service calls documented with contracted pest control provider during the dates between 07/01/16 and 07/27/16.
-The weather got hot and bed bugs came out in room 300 "and other places" (the ED was not sure of the date) which is what prompted the heat treatment in 08/2016 of the 23 rooms.
-At the end of July 2016 or early August 2016, the ED notified the Regional Director of Operations (RDO) that a different type of treatment was needed to treat the bed bugs because the treatment being used was not working.
-When staff found bed bugs, they were supposed to notify the ED or MCM verbally or in writing but were not expected to keep documentation of bed bug activity.
-"Maybe the beginning of last week," a staff notified the ED of a bed bug on the wooden headboard of a residen't's bed. (The ED could not remember which resident).
-The headboard was removed and the bed linen was changed; the bed was cleaned.
-The resident was not moved out of the room.
-The contracted pest control provider was not notified; "it was only one bed bug."
-"How do I determine when to treat or call?" (treat for bed bugs or call the contracted pest control provider).
-The ED had no explanation why multiple staff reported seeing bed bugs and notifying the ED

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and/or MCM when staff had not notified him (ED) or the MCM.

Review of copies of email correspondence provided by the ED revealed:
-There was documentation in an email dated 07/20/16 of the ED emailing the contracted maintenance provider which read "Wanted to know if you could send the K-9 (dog) out to sniff out the rooms with bed bugs, we're starting to have an increase of them in resident rooms."
-There was documentation in an email dated 07/21/16 of the Regional Director of the contracted maintenance provider responding to the ED's email dated 07/20/16.
-There was documentation in an email dated 07/27/16 from the Regional Director of the maintenance provider which read "Be aware that our K-9 team just left [facility name] and found severe issues. Note in the report the BBs (bed bugs) are coming from cracks in the ceiling and from outlets... alert in rooms [15 room numbers listed], laundry room, nurses' station, memory care office. Bed bugs are visibly crawling on walls and ceiling. One of the K9s had live bed bugs on him after the inspection."
-There was documentation in an email dated 07/27/16 of the ED notifying the RDO of the findings from the K-9 inspection.
-There was documentation in an email sent to the ED and RDO dated 08/01/16 from corporate management that corporate management was working with the contracted pest control provider about a new heat treatment procedure and was working to ascertain the best course of action to take to treat the bed bugs.

Confidential staff interviews revealed:
-The facility did not have any type of routine schedule to monitor for bed bugs; one of the

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housekeepers looked for bed bugs whenever she was cleaning.
-Nothing had been done after the treatments to check for or prevent the bed bugs.
-All staff were told to "be on the look-out" for bed bug activity.
-The only system used for the bed bugs was to report the bed bugs to the ED and/or MCM; "sometimes something might get done, sometimes it won't."
-Staff did not document when bed bugs were observed.
-The housekeepers checked for bed bugs but there was no communication between housekeeping, management, and other staff about who was supposed to monitor for bed bugs.
-Staff had not observed any routine inspections by staff or management of the facility for bed bug activity.
-Staff were not aware of any special protocols or any type of routine inspections for bed bugs except that housekeepers were responsible to inspect for bed bug activity but any staff who saw activity should report it.
-When the facility was last treated for bed bugs (08/2016), the ED "rubbed it our face" (staff's face) "because it cost so much;" the ED was "so mad."

Interview with a housekeeper on 09/08/16 at 8:30 a.m. revealed:
-The housekeeper would use a vacuum for cleaning in the resident rooms every other day.
-The housekeeper had never seen any roaches or bedbugs in the facility.
-Some of the furniture in the resident rooms was too heavy and could not be moved to clean behind or under those pieces of furniture.

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D 338	Continued From page 80 Interview with a second housekeeping staff revealed: -The facility had bed bugs and was previously treated with a heating procedure two times; "heat kills them" (bed bugs). -The housekeeper felt like the facility was treated timely for the bed bugs; "we've done the best we can." -The housekeeper was unsure of the date of the first bed bug treatment, but thought the treatment took place "a few months before" the last treatment (in August 2016). -The last bed bug treatment (in August 2016) was "more thorough" than previous treatment. -During the time between the two heat treatments, the housekeeper observed "some activity" of bed bugs in areas such as power "receptacles, wood, and places like that." -The housekeeper knew there was bed bug activity present between the two heat treatments because bed bug droppings were observed on residents' beds and headboards. -The housekeepers process for monitoring for bed bugs was as follows: 1) report bed bug sightings to the ED; 2) spray the bed with a specified bed bug spray after the bed linen had been stripped by the PCAs; 3) vacuum and clean the room; 4) keep a check on the room to assure the bed bugs "cleared up." -The facility did not keep any written documentation of when or where bed bugs were observed. -Facility management had been responsive to her reports of bed bug activity; "[ED's name] takes care of it." -Housekeeping staff were responsible for checking for bed bugs while they were performing their daily cleaning of the facility. -When other staff members observed bed bugs, the staff notified the housekeeper; then the	D 338		

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housekeeper notified the ED.
-The facility's one other housekeeper reported bed bug activity to her.
-All resident rooms and empty rooms were supposed to be cleaned every day which included a thorough vacuuming with the shop vac; the shop vac had "good suction."
-In order to prevent bed bugs, the housekeeper vacuumed the areas bed bugs lived in such as the edges and corners of the beds, bed rails, and furniture.
-The housekeeping staff also vacuumed behind and under all furniture (including heavy furniture such as dressers) every day.
-After each of the two heat treatments, there had not been any new procedures or implementation of any precautions to decrease or prevent the bed bugs from returning; housekeeping staff kept the same cleaning routine.

Confidential telephone interview with a family member revealed the family member expected the facility to have a system in place to monitor for and treat for bed bugs.

Interview with the ED on 09/09/16 at 11:58am revealed:
-The facility did not have a set schedule for monitoring for bed bug activity; the housekeepers looked for bed bugs as they cleaned and other staff should be looking for bed bug activity while on duty.
-The facility did not have a tracking protocol to document the rooms, beds, or other areas with bed bug activity or suspicious activity.
-Housekeeping staff had not been trained and were not expected to keep written documentation of bed bug activity and suspicious bed bug activity.
-After treatments for the bed bugs, the facility

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used their same/ordinary housekeeping cleaning protocol and schedule.
-The facility purchased more vacuum cleaner bags and purchased 2 cases of spray from the contracted pest control provider after the last bed bug treatment.

Interview with the Operations Manager (OM) of the contracted pest control provider on 09/12/16 at 09:15am revealed:
-There was a "binder" the facility could document any bed bug activity observed by staff.
-The OM thought the binder was kept in the ED's office.
-Staff could also notify the pest control provider by calling a 1-800 telephone number.

Observation on 09/12/16 at 10:30am of a blue notebook in the ED's office identified as the contracted pest control provider's activity/tracking blue binder revealed there was no documentation by facility staff in the binder on any date.

Interview with the ED on 09/12/16 at 10:30am revealed the contracted pest control provider was responsible for documenting activity in the blue binder.

Observation of the ED and RDO on 09/12/16 at 10:30am revealed the RDO told the ED that the contracted pest control provider left a service report in the binder for each visit and facility staff were responsible for documenting activity in the blue binder.

Interview with the RDO on 09/12/16 at 10:30am revealed:
-The facility did not have a set schedule to monitor for or document bed bug activity prior to the previous week.

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D 338	Continued From page 83 -The RDO provided the surveyor with a copy of a "Bed Activity Site Tracking Log" which was implemented in the facility "last week." Review of copies of the "Pest Prevention Service Reports" (PPSR) which documented the services provided by the contracted pest control provider to the facility revealed: -From 12/31/15-07/01/16, there was documentation of the contracted pest control provider treating various resident rooms for bed bugs using various treatment methods for on eleven separate occasions: 12/31/15, 02/05/16, 02/07/16, 02/10/16, 03/02/16, 03/08/16, 03/11/16, 03/15/15, 03/17/16, 05/26/16, 07/01/16. -07/01/16: "Performed extra service for bed bugs today;" room 203 was noted with "light" bed bug activity and treated with the "heat chamber." In the "Pest activity found" section, there was documentation of "light" bed bug activity in "resident rooms." -07/28/16: "Inspected 26 resident rooms as well as laundry, nurse station and hallways. 21 resident rooms were active. Activity was found in outlets, on ceilings, around fire detectors, headboards, mattress [sic], and behind pictures. Major concerns are cracks and cervices [sic] in building." In the section labeled "Recommended Client Corrective Actions," there was documentation which read "repair holes, cracks, and gaps in or near the ceiling. They could serve as harborage areas. Structural repairs needed." -08/09/16-08/19/16: The pest control provider was at the facility on 8 different dates to perform treatment for bed bugs in multiple rooms on each date of the 8 dates. -09/01/16: No bed bug activity was found in the facility on that date.	D 338		

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Review of the "Pest Prevention Job Agreement" dated 08/01/16 revealed:
-"It has been determined 21 rooms have bed bug activity. All rooms with activity will be heat and chemical treated."
-"Rooms without activity will be treated chemically."
-"The customer further agrees to cooperate as needed to perform the pest prevention service and to correct conditions conducive to pest infestations as indicated on the service report."

Interview with the Operations Manager (OM) for the facility's contracted pest control provider on 09/12/16 at 09:15am revealed:
-The facility had been treated for bed bugs with conventional treatment (chemical spray or powder), the heat chamber (a pod-like set up in a specified room where furniture was brought and treated), and glycol heat (an exterior trailer which treated the entire room).
-The facility had a 90 day warranty for each area after treatment.
-The pest control provider documented information for the facility which would "aid in the elimination of the pests" in the "Recommended Client Corrective Action" section on the PPSRs.
-On 07/01/16, the pest control provider was onsite at the facility to inspect and treat only one room for bed bugs (room 203).
-On 07/28/16, the pest control provider was onsite to "assist" canine four units during inspection of the entire property after being contacted by the facility's corporate office.
-If the canine "alerts," the pest control technician went in and checked the room for bed bugs.
-No treatment was completed on 07/28/16, there was only inspection completed.
-The PPSR dated 07/28/16, contained information on repairs recommended to "aid in

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the elimination of the bed bugs" in "Recommended Client Corrective Action" section.
-Between 07/01/16 and 07/28/16, the facility "probably was not aware" of the amount of bed bug activity on the property.
-The weather had gotten really hot that week (week of/prior to 07/29/16) and the contracted pest control provider "was probably not aware" of the bed bug activity in the facility between 07/01/16 and 07/28/16.
-Up until 07/01/16, any bed bug activity that had been found in the facility was treated."It looks like they did a good job up until that point."
-The OM felt like the facility like did not have knowledge of the "systemic problem" during the time between 07/01/16-07/28/16 and that time frame was a "planning period" for the facility.
-If the facility had observed bed bug activity between 07/01/16 and 07/28/16, the pest control provider would expect the facility to notify the pest control provider.
-After review of the facility's work orders and PPSRs, the OM was able to locate one service call to the facility dated 07/27/16; there were no other reports or service calls on file with the pest control provider dated between 07/01/16 and 07/27/16.
-The OM did not know what occurred between 07/01/16 and 07/28/16; the OM had no explanation as to why there was only bed bug activity noted in room 203 on 07/01/16 but on 07/28/16, there was bed bug activity found in 21 rooms and bed bugs were visible on the multiple areas noted on the PPSR dated 07/28/16.

Review of email correspondence on 09/12/16 at 09:30am received by the OM from the facility's contracted maintenance provider regarding the bed bug activity in the facility dated 07/27/16 on the OM's smart telephone revealed "note change

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in behavior in hallways and bed bugs visibly crawling on ceilings and walls."

Confidential staff interviews revealed prior to the last treatment (in August 2016), the ED addressed the bed bug problem at a staff meeting and told staff he was "waiting on corporate to email us back. "

Confidential interview with a second staff revealed:
-In the past, when staff reported bed bug activity to management (ED and MCM), staff were told they were waiting on "corporate" (facility's corporate office) for treatment.
-The ED and MCM never gave staff a reason why it took so long to treat the facility for bed bugs (prior to the last treatment in August 2016).

Confidential interview with a third staff revealed:
-"Two and a half weeks ago" a resident's family brought in an outdoor type spray because she had observed bed bugs in the resident's room.
-The ED was aware of the bed bug activity seen by the family member in the resident's room.
-The resident's room had not been treated after the bed bugs had been observed.

Confidential interview with a family member revealed:
-The "whole building was infested with bed bugs" in June and July 2016; the facility treated for the bed bugs in August 2016.
-Bed bugs were on the edges of the ceiling and walls, coming out of the electrical sockets, and falling from the ceiling in the middle of the day.
-The family member had "never seen anything like it in my life."
-The family member reported the bed bugs to the ED.

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-The ED notified the corporate office "but his hands were tied."
-The family member would have contacted the news but was afraid to say more because the family member was afraid the facility would "move" the resident.
-It took two weeks for the facility to address the family member's concerns.

B. Observations, record reviews, and interviews revealed live bed bug activity was confirmed in Resident #8's room on 09/09/16 and 09/13/16. After the bed bug activity was observed in Resident #8's room on 09/09/16 and confirmed by the contracted pest provide on 09/09/16, Resident #8 was moved from her normal room in to an alternate room. Resident #8 was still residing in the alternate room when the bed bug activity was observed in her (alternate) room on 09/13/16. The facility failed to follow their established bed bug protocol to remove Resident #8 from her bed, bathe her, change her clothing and linen, complete a skin assessment, and remove the resident from her room after a live bed bug was observed crawling on Resident #8 on 09/13/16.

Review of Resident #8's current FL-2 dated 02/18/16 revealed diagnoses included Alzheimer's dementia, history of falls and muscle weakness.

Confidential staff interview revealed:
-Staff had seen live bed bugs on C hall in Resident #8's room after the heat treatment was completed in August 2016.
-Resident #8's room had not been treated during the last heat treatment in August 2016.

Confidential interview with a second staff

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revealed:
-When the staff received shift report from another staff at the start of the shift that day (date and time withheld per staff request to maintain confidentiality), the staff was told "to be careful" because live bed bugs had been observed Resident #8's (normal assigned) room on the previous shift (date and time withheld per staff request to maintain confidentiality).

Confidential interview with two staff revealed a live bed bug was found by staff on Resident #8's bed on that date (date withheld at staff request to maintain staff confidentiality).

Observation of Resident #8 09/13/16 at 08:46am revealed:
-Resident #8 was lying in bed with her eyes closed.
-Resident #8 was moaning unintelligibly.
-Resident #8 had on a white blouse.
-Resident #8's bed had white bed sheets and a light green colored bed spread.
-A live bed bug crawled across Resident #8's right shoulder down towards the foot of the bed.

Observation and interviews with two staff on 09/13/16 at 08:50am revealed:
-Two staff were standing near the front desk documenting on the bed bug activity log.
-Staff had just removed a bed bug from Resident #8's bed and flushed the bed bug down the toilet.
-Staff had just notified the MCM about the bed bug found on Resident #8's bed.

Observation of Resident #8's room on 09/13/16 from 08:46am through 10:00am revealed:
-At 09:21am, Resident #8 was still in bed, had on the same clothing, and the same beds linens were still on the bed as had been observed earlier

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D 338	Continued From page 89 (on 09/13/16 at 08:46am). -At 09:22am, a staff went to the door to Resident #8's room and looked inside; the staff did not go inside Resident #8's room. -At 09:59am, Resident #8 was still in her room in bed. -At 10:00am, the MCM walked past Resident #8's room and did not look in or go in to Resident #8's room. -At no time between 08:46am and 10:00 am did any staff go in to Resident #8's room to change Resident #8's clothing or bed linen, remove Resident #8 out of the bed/room inspect Resident #8's bed or room for bed bug activity, assess Resident #8's skin for bed bug bites, or clean the room. Interview with the MCM on 09/13/16 at 10:00am revealed: -Since the last heat treatment for bed bugs, the MCM had not observed or heard any reports of bed bug activity until that day (09/13/16). -Today (09/13/16), "about 30 minutes ago," two different (named) staff reported observing bed bug activity on two different (named) residents. -Resident #8 was one of the named residents. -When asked when staff had observed the bed bugs, the MCM responded "I guess this morning." -The MCM did not know where the bed bugs had been found. -The MCM did not know if the bed bugs were alive; "they didn't tell me that." -The MCM told the two staff members to write a note to document their observations and "put it in the bed bug log book." -The MCM gave the two staff members' written notes to the ED as soon as she received them. -The MCM had not checked on the issue that morning (09/13/16) because she had not had time.	D 338		

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-The ED "will take care of it."
-The protocol the facility was supposed to follow for bed bug activity was for staff to notify the MCM and/or ED, bathe or shower the resident, check the resident's skin, change the resident's bed linen, move the resident out of the room, check the room, and management was supposed to call the contracted pest control provider.
-The MCM did not think the protocol had been followed that day (09/13/16); "unless the Med Tech told them to do it."
-Staff knew what to do; the MCM should not have to tell staff what to do.
-The MAs on duty were considered the Supervisor and were responsible for making sure the protocol was followed.
-The MAs should know what to do; the MCM could not be everywhere.
-When interviewed regarding the observations in Resident #8's room between 08:46am-10:00am that day (09/13/16) and the facility bed bug protocol was not observed to be followed, the MCM said she would go ask staff if protocol had been followed and would check herself to see if the protocol was followed.

Interview with the ED on 09/13/16 at 10:35am revealed:
-The ED received a "yellow note" from the MCM that morning (09/13/16) that a staff saw a bed bug on Resident #8's bed that morning (09/13/16).
-The ED could not recall which staff reported observing the bed bug on Resident #8's bed.
-It did not make sense because bed bugs were nocturnal and "would not be out right now."

Interview with the Regional Director of Operations (RDO) on 09/13/16 at 10:45am revealed:
-The facility had a standard protocol in place for

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when a bed bug was observed; the protocol was expected to be followed.
-When the RDO was notified of the observations from 08:46am through 10:00am on 09/13/16, the RDO assured the established bed bug protocol would be initiated as soon as possible.
-The RDO expected the protocol to have been followed when the bed bug was found on Resident #8's bed on 09/13/16 at 08:46am.

Interview with the ED on 09/13/16 at 11:15am revealed:
-The be bug protocol was in place and was expected to be followed.
-The ED had not received two notes that day (09/13/16) about the bed bug activity; the MCM had only given the ED one note written by staff stating that bed bugs had been found earlier that morning (09/13/16).
-The ED was "disappointed" in his staff because staff were not following protocol.
-"Staff are vindictive."
-The ED believed staff brought in the bed bugs.
-The staff "put the bed bug there to sabotage me."

Interview with Resident #8's family member on 09/09/16 at 11:56am revealed:
-The family had never been notified of any bed bugs or any bed bug treatment until that day (09/09/16).
-The family member expected to be notified of any bed bug activity.

Interview with another family member of Resident #8 on 09/14/16 at 11:30am revealed:
-Resident #8 was a hospice patient.
-The family had no knowledge that staff found bed bug activity in Resident #8's room that day (09/14/16).

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D 338	Continued From page 92 Based on observations, record reviews, and interviews, Resident #8 was not interviewable. Interviews and record reviews revealed the facility failed to follow the established protocol of completing skin assessments after Resident #11 was found with bites on her skin and bed bug activity in her room. Review of Resident #11's current FL-2 dated 02/29/16 revealed diagnoses included Alzheimer's, hypertension, and diabetes. Confidential staff interviews revealed -"Quite a few residents had bed bug bites on them." -Nine different (named) residents were identified by staff as having had bed bug bites within the time frame of the last time the facility was treated for bed bugs in August 2016. -Resident #11 was one of the 9 residents named by staff with bites. -"They (the ED and MCM) never did anything about the residents who had bites." Observation and interview of a staff revealed: -The staff became tearful when discussing the bed bugs. -Bed bugs had "eaten some of them alive." -The staff would not want their family member treated that way. Confidential interview with a second staff revealed Resident #11 was "ate up" with bed bug bites. Confidential interview with a third staff revealed: -Resident #1 was "eaten up" with bites at the end of July (2016).	D 338		

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D 338	Continued From page 93 -The bites were reported to the ED and MCM. Confidential interview with a fourth staff revealed: -Resident #11 had bites "mostly on her arms and neck" "at least 2-3 months ago." -Resident #11 told staff she saw bed bugs in her bed. Interview with the ED and MCM on 09/07/16 at 12:49pm revealed: -Resident #11 complained of bed bug bites but bed bugs were not found in her room. -Resident #11 scratched herself on her forearms and her forearms "were red." -Resident #11 saw the facility physician about her complaints. -It was unknown if Resident #11 actually had bed bug bites. Interview with the ED on 09/07/16 at 4:15 p.m. revealed: -Facility staff thought Resident # 11 had bed bug bite marks on her skin but later found out this was related to another skin diagnosis. -Resident #11's room had a "clutter full" of clothes, when the pest control provider came out, a canine was used to see if any bed bugs were detected Resident #11's room. -The canine circled around in Resident #11's room and did not pinpoint one spot for bed bug activity. -The facility added Resident #11's room to be treated for bedbugs and the room was treated. Review of the Pest Prevention Service Report (PPSR) dated 02/10/16 revealed: -Resident #11's room had "light" bed bug activity. -Resident #11's room had been treated with the "heat chamber" on that date for bed bugs.	D 338		

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D 338	Continued From page 94 Interview with the MCM on 09/09/16 at 1:28pm revealed Resident #11 had "what appeared to be bites...a while ago." Review of a "Visit Note/Progress Notes" for Resident #11 dated 06/01/16 from the contracted primary care provider (PCP) office revealed: -"Today's visit was requested by the patient for further assessment of rash she has been attributing to bedbug bites. At times, the rash did seem consistent with some type of insect bite, possibly bedbugs, but facility reports they themselves have searched the patient's room multiple times and have had pest control companies search and even treated the room and nobody has found any evidence of bedbugs or other insects." -Resident #11 had "advance Alzheimer's disease with dementia, so history taking is limited ..." Review of a "Visit Note/Progress Notes" for Resident #11 dated 05/18/16 from the contracted PCP office revealed: -'Today's visit was requested by patient for further assessment of recurring pruritic (itching) and erythematous (red) lesions on upper and lower extremities (arms and legs). Patient reports that she has seen tiny little black bugs in her bed. Staff has called in pest companies to spray for these in the past, but the patient has continued to have symptoms with apparently new lesions occurring at least every few nights." -"The erythematous, raised pruritic lesions seem to occur in batches of 2 to 5 bites in each area, with no lesions in between these batches." -Resident #11 "currently has no lesions on her trunk, but has multiple lesions on all extremities." -Resident #11 "does not seem to respond" to topical anti-itch medications and did not improve with "steroids."	D 338		

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D 338	Continued From page 95 Review of a "Visit Summary" for Resident #11 dated 03/10/16 revealed: -"Plan: bedbug bites on upper and lower extremities." -"Treat symptomatically with steroid cream." -"Staff has hired professionals to exterminate the bedbugs." Telephone interview with a patient and provider support staff member at the facility's contracted PCPs office on 09/08/16 at 5:16pm revealed the provider who signed the "visit summary" on 03/10/16, 05/18/16, and 06/01/16 was no longer employed by the contracted provider and was not available for interview. Telephone interview with the facility's current contracted physician on 09/12/16 at 6:45pm revealed: -The physician had been the PCP for the facility about 3 months. -During the 3 months the physician had been working at the facility, the physician had not observed Resident #11 with any bites. -About two weeks ago, the facility notified the physician that Resident #11 had a right groin rash. -The rash looked like a fungal rash; the physician wrote a prescription for Resident #11 to treat the rash. Review of Resident #11's record revealed there was only one skin assessment in the record which was dated 07/05/15. Interview with the MCM on 09/09/16 at 1:28pm revealed: -Resident #11 had "dry skin." -Resident #11 always said "something is biting	D 338		

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her."
-During the time of the last bed bug treatment (08/2016), Resident #11's inner forearm was red but there were not any bites on it.
-The MCM did not know if bed bug activity had been found in Resident #11's room.
-Staff were supposed to complete skin assessments whenever "anything out of the ordinary" was first noticed on a resident's skin.
-The staff observing the skin concern was responsible for completing the skin assessment.
-After the skin assessment was done, staff were supposed to be put in the "bucket list" binder at the nurses' station and were supposed to notify the physician as needed.
-The MCM reviewed the skin assessment forms in the bucket list folder and then the Medication Aides were supposed to file the assessments in the resident's record.
-Upon review of Resident #11's record, the MCM acknowledged that there was only one skin assessment in the record.
-The MCM would check in Resident #11's old record to see if there were any more skin assessments; if there were any more skin assessment forms, the MCM would give a provide a copy of the skin assessments.
-All staff were supposed to follow the skin assessment policy.

The MCM never provided any additional skin assessments for Resident #11.

C. Based on interviews, the facility failed to assure all staff were trained on the facility's established bed bug protocol.

Confidential staff interviews revealed:
-Staff members were told not to tell other staff members about the bed bug infestation at the

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facility.
-Staff were told to keep it "hush, hush."
-The MCM told staff not to report the bed bugs to newly hired staff and new staff had taken bed bugs home because they did not know about them.
-Staff had not seen any instruction form or received training on what to do if bed bugs were seen other than to report the issue to the supervisor.
-The last staff meeting was about 3 or 4 weeks ago.
-The facility did not have staff meetings often.
-About one week prior to the treatment in August 2016, staff were instructed to implement a procedure which included drying, washing, and then re-drying clothing/laundry brought in by families to residents; the procedure was still in place.

Interview with the ED and the MCM on 09/07/16 at 12:45 p.m. revealed
-The contracted pest control personnel trained the facility's staff regarding the facility's bed bug infestations in a morning meeting, then the information was passed to 2nd and then third shift.
-There was no agenda available for those meetings.
-The ED educated himself on bed bug infestations.
-Home Health was included in the bed bug infestation education.

Confidential staff interview revealed:
-The staff had never been instructed on a specific protocol or reporting process if bed begs were seen in the facility.
-The staff learned that the facility had a bed bug problem from the staff who trained the staff but

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no process was provided on what to do if bed bugs were seen.
-The staff was trained by at least 4 different staff.
-The staff had never heard of a dry, wash, dry process for laundry when bed bug activity was observed.

Confidential interview with a second staff revealed:
-The staff were supposed to notify the ED or MCM when bed bugs were observed.
-The staff was not sure what the process was after notifying management.
-The staff had never received any training on the process to follow when bed bugs were found; but the staff had heard other staff talking about the process.

Confidential interview with a third staff revealed:
- The staff had not received any training on the protocol to follow for bed bugs except the ED told staff to keep any bed bugs found to show to their supervisor.
-When the staff found a bed bug, the staff reported it to their supervisor, which were the Medication Aides and/or the MCM.

Interview with the MCM on 09/13/16 at 10:00 a.m. revealed:
-The last staff meeting was done around the middle of August 2016.
-There had been new employees hired after the last staff meeting in August 2016.
-The newer staff members received facility information from other staff members.

Interview with the MCM on 09/13/16 at 3:45 p.m. revealed the MCM was not sure if newly hired staff were trained on the bed bug protocol because the business office manager (BOM)

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D 338	Continued From page 99 conducted staff orientation. Interview the BOM on 09/09/16 at 11:50am revealed: -The BOM was responsible for new staff orientation. -There was no training or information provided to staff about bed bugs at orientation. -The ED had instructed the BOM not to tell new staff about the bed bugs. Interview with the ED on 09/09/16 at 11:58am revealed: -There was a staff meeting on 07/07/16 in which the ED told staff to be "proactive" in looking for and reporting bed bugs; the ED did not have any written documentation of this staff meeting. -The ED had educated staff on an ongoing basis about the bed bugs, treatment, and protocol. --The information was communicated to staff at the morning meetings. -There was no written documentation provided to staff on training related to bed bugs. -The protocol/bed bug information had not been communicated to new staff. -The facility had "maybe 4 or 5" new staff that had not received training on bed bugs or the protocol. The facility's failure to implement measures to protect Resident #4 from the aggressive actions of Resident #3, resulted in Resident #4 sustaining a hip fracture after being pushed down by Resident #3; and failure to implement their established bed bug protocol and train all staff on the bed bug protocol resulted in the re-infestation of bed bugs in Resident #11's room and alternate room. This noccompliance constitutes a type A1 Violation for serious harm and neglect. Review of the Plan of Protection submitted by the	D 338		

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D 338	Continued From page 100 facility dated 09/14/16 revealed: -The Regional Director of Operations (RDO) would facilitate an internal investigation to include but not limited to and observations with staff and residents. -Resident in question would be placed on 15 minute monitoring checks during investigation. -A licensed Nurse provider would provide training to all staff on the requirements of reporting allegations, internal investigations, resident rights, and Health Care Personnel Registry (HCPR). -The ED, RDO, Quality Assurance Nurse, and/or Clinical Support Team will monitor compliance with reporting, investigations, allegations, and HCPR reporting requirements. -If any residents shows signs of aggression, physician will be contacted and resident will be sent out for observation. -The contracted pest control provider was immediately dispatched to perform visual inspection and spot treatment for bed bugs. -Residents were removed from rooms with bed bug activity until the contracted pest control provider could complete treatment on the rooms. -The contracted pest control provider would perform regular inspections and treatments as needed. -Responsible parties would be notified of any outbreaks or treatments needed. -A daily bed bug sighting log had been implemented. -Residents' rights in-service would be scheduled/conducted for staff by Ombudsman. -Ongoing training would be conducted periodically during monthly staff meetings. -If residents' clothing was contaminated with bed bug activity, it would be cleaned and returned to the resident. CORRECTION DATE FOR THIS TYPE A1	D 338		

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D 338	Continued From page 101 VIOLATION SHALL NOT EXCEED OCTOBER 14, 2016.	D 338		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to notify the physician and implement additional supervision and/or safety interventions to prevent residents from harm from a resident (#3) who was known not to like other residents in or near his room and had a history of pushing another resident (#4) on multiple occasions who wandered into his room.	D 456		

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D 456	Continued From page 102 The findings are: Review of Resident #3's current FL-2 dated 08/03/16 revealed diagnoses included Alzheimer's dementia, Asperger's Syndrome, tardive dyskinesia, and coronary artery disease. Review of Resident #3's assessment and care plan dated 08/02/16 revealed: -Resident #3 was sometimes disoriented. -Resident #3 was forgetful, "needs reminders." Confidential staff interview revealed: -Resident #3 did not like other residents to come in his room. -When/if "walkers" stopped at Resident #3's door or went in his room, Resident #3 "yelled" for them to "get out." -Resident #3 can become jittery and anxious at times when others got around him. -The staff heard incidents when Resident #3 was "loud" and telling Resident #4 to "get out." -When the staff "ran to see what was going on" the staff had observed Resident #3 "push" Resident #4 out of his room a "couple times." (The staff was not sure of the dates). -There were not any interventions implemented by the staff to address Resident #3's behaviors toward Resident #4 except staff would re-direct Resident #4 away from Resident #3's room. Confidential interview with a second staff revealed; -About 2 weeks ago, a female resident was in her wheelchair down the hall toward Resident #3's room; the staff could tell by Resident #3's body language and loud tone of voice he was irritated. -Resident #3 pushed the female resident in her wheelchair to the nurses' station.	D 456		

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D 456	Continued From page 103 Confidential interview with a third staff revealed: -Resident #3 did not like anyone in his room. -Resident #3 got "agitated" when anyone went in his room. -When Resident #4 went in to Resident #3's room, staff would re-direct Resident #4 out of Resident 3's room. Confidential interview revealed: -On 08/11/16, a staff member reported to two other (named) staff that Resident #3 "shoved" Resident #4 and Resident #4 fell to the floor. -Resident #4 was sent to the emergency room (ER) for a broken hip. Interview with a resident on 09/14/16 11:20am revealed: -Resident #4 went in Resident #3's room "and acted like it was his." -"[Resident #3's name] did push [Resident #4's name] that one time because he would not leave." -Resident #3 "closed the door" and Resident #4 "never came back." Interview with Resident #3 on 09/13/16 at 3:10pm revealed: -Resident #4 was a "regular torment" in Resident #3's "apartment" before he had his accident (on 08/11/16 when he fractured his hip) and had to get a wheelchair. -Resident #4 wandered in to Resident #3's room "at all hours." -Staff "don't do much to stop him (Resident #4)." -The last time Resident #4 wandered into Resident #3's room was about "one month ago." -Resident #3 "slammed the door" on Resident #4 "to try to get him out of here." (Resident #3 did not know the date he slammed the door on	D 456		

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Resident #4.
-"Then he (Resident #4) was gone for two to three weeks after that date and then returned back (to the facility), but now he's in a wheelchair."

Interview with the Memory Care Manager (MCM) on 09/13/16 at 4:35pm revealed:
-The MCM "thinks one time" Resident #3 "reached out and hit" Resident #4.
-The MCM was "not really sure" of the date of the incident.
-The MCM did not know if an incident report was completed for the incident.

Review of Resident #3's record revealed there was no documentation in the record about Resident #3's behaviors, notification of the primary care provider, or additional interventions implemented to assure residents who wandered near or in to Resident #3's room were kept safe from physical harm by Resident #3.

Review of Resident #4's current FL-2 dated 09/03/16 revealed:
-Diagnoses included Alzheimer's, muscle weakness, and moderate protein calorie malnutrition.
-Resident #4 was constantly disoriented.

Confidential staff interviews revealed:
-Prior to Resident #4's fall and hip fracture on 08/11/16, he was a wanderer.
-Resident #4 would wander in to other residents' rooms and required frequent re-direction.

Telephone interview with Resident #4's Power of Attorney (POA)/family member on 09/08/16 at 5:40pm revealed:
-Resident #4 was never himself due to his

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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medical diagnoses.
-Since being admitted to the facility, Resident #4 had "several injuries", 5 or 6 falls, and 3 or 4 hospitalizations.
-Resident #4 fell and broke his hip in 08/11/16.
-The POA was not aware of any interventions implemented by the facility to address Resident #4's wandering, falls, or injuries.
-The POA wondered if Resident #4 was being abused.
-The POA called the Executive Director (ED) to discuss his concerns sometime between 08/03/16 and 08/11/16 when Resident #4 broke his hip. (The POA could not recall the exact date but was sure of the time frame because Resident #4 fell on 08/03/16 and fell again on 08/11/16).
-The POA asked the ED to conduct an investigation for abuse.

A second telephone interview with Resident #4's POA on 09/14/16 at 2:19pm revealed:
-Resident #4 was being injured "frequently" and the POA was "concerned."
-The POA called the ED because the POA wanted the ED to look to see if anyone was abusing Resident #4.
-The POA had "genuine concern" and was not "accusing" any specific person of abusing Resident #4.

Interview with the MCM on 09/13/16 at 4:35pm revealed:
-Resident #4 was "never oriented," wandered, went in to other residents' rooms when he could walk, but "means no harm to anyone."
-Resident #4 would walk down the halls often talking to himself and looking for his "kitty" (prior to fracturing his hip on 08/11/16).

Based on observations, record reviews, and

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D 456	Continued From page 106 interviews, Resident #4 was not interviewable. Interview with the ED on 09/14/16 at 12:25pm revealed: -"Staff were claiming [Resident #3's name] pushed [Resident #4's name]." -The Activity Director (AD) and an "Aide" said Resident #3 pushed Resident #4 on 08/03/16 and Resident #4 fell, "or it could be when he (Resident #4) fell on 08/11/16." -The ED was unsure of the date. -The ED could not recall which Aide made the statement. -The ED heard the AD saying to other staff that Resident #3 pushed Resident #4 and Resident #4 fell. -It was reported to the ED at a "stand up" (daily staff meeting) that Resident #3 closed the door on Resident #4 (the ED did not know the date of the report). -Resident #3 "doesn't have a track record of abusing others residents." -The ED had reviewed the incident reports dated 08/03/16 and 08/11/16 and saw no reason to investigate based on the details documented on the incident reports. -The ED did not witness any incidents and could only go by what was documented on the incident reports. -No further action was taken after the incidents. -Resident #4 wandered and other residents had also closed the door on Resident #4. -The ED's expectation on resident to resident abuse was "zero tolerance," -The ED would ask the MCM if she had additional documentation about the incidents or documentation of physician notification. -If any additional documentation was found, the ED would provide copies of the documentation.	D 456		

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D 456	Continued From page 107 Interview with the ED and MCM on 09/14/16 at 2:00pm revealed: -Staff re-directed Resident #4 as needed. -Resident #4 had "a right to walk." -The facility had not implemented any additional monitoring or other interventions to keep Resident #3 from harming Resident #4 or other residents. -The physician was not notified of the incidents. -"There was nothing to investigate." -The incident reports had been done; nothing else needed to be done. Interview with the facility's contracted primary care provider (PCP) on 09/12/16 at 12:07pm revealed: -The PCP did recall ever being notified of Resident #4 being injured by another resident. -The PCP did not recall ever being notified of any resident with abusive behaviors towards other residents. -The PCP would expect to be notified of any behavior or abuse. Additional documentation related to Resident #3's behaviors, additional incident reports, and any other documentation of interventions implemented by the facility to protect residents from harm was requested from the ED and MCM; however no other documentation was provided. Review of the Plan of Protection submitted by the facility dated 10/07/16 revealed: -The facility would address accidents and incidents according to the state rules and regulations. -Facility would conduct training on accident reporting and residents' rights. -Training would be reinforced during "stand up" meetings.	D 456		

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D 456	Continued From page 108 THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2016.	D 456		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure the minimum staffing requirements were maintained to meet the needs of the residents in the special care unit (SCU) for 32 of 42 shifts sampled from 08/01/16-08/07/16, 08/19/16-08/22/16, and 09/03/16-09/05/16. The findings are: Confidential staff interviews on first, second, and third shifts revealed: -"Not enough staff work here." -It was hard to give quality care to the residents when work shifts were understaffed. -"They don't schedule enough people." -There was not enough staff scheduled to "care	D 465		

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for residents' needs."

Review of the Master Schedule by Shift (MSBS) for August 2016 revealed:
-First shift hours were documented as 07:00am-3:00pm.
-Second shift hours were documented as 3:00pm-11:00pm.
-Third shift hours were documented as 11:00pm-7:00am.

Review of the "Census Daily Detail" Report (CDDR) dated 08/01/16 revealed the facility census was 55, requiring 55 hours of staff time on first and second shifts and 44 hours of staff time on third shift.

Review of the "Punch Detail" Report (PDR) dated 08/01/16 revealed the facility was short in staffing hours on all three shifts: only 38.42 staff hours were provided on first shift, 44.25 hours on second shift, and 37.07 hours on third shift.

Review of the CDDR dated 09/02/16 revealed the census was 55, requiring 55 hours of staff time on first and second shifts and 44 hours of staff time on third shift.

Review of the PDR report dated 08/02/16 revealed the facility was short in staffing hours on all three shifts: only 44.4 staff hours were provided on first shift, 34.54 hours on second shift, and 24.93 hours on third shift.

Review of the CDDR dated 08/03/16 revealed the census was 53, requiring 53 hours of staff time on first and second shifts and 42.4 hours of staff time on third shift.

Review of the PDR dated 08/03/16 revealed the

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facility was short in staffing hours on second shift with only 37.78 staffing hours provided and short on third shift with only 23.23 staffing hours.

Review of the CDDR dated 08/04/16 revealed the census was 53, requiring 53 hours of staff time on first and second shifts and 42.4 hours of staff time on third shift.

Review of the PDR dated 08/04/16 revealed the facility was short in staffing hours on second shift with only 38 staffing hours and short on third shift with only 29.12 staffing hours.

Review of the CDDR dated 08/05/16 revealed the census was 54, requiring 54 hours of staff time on first and second shifts and 43.2 hours of staff time on third shift.

Review of the PDR dated 08/05/16 revealed the facility was short in staffing hours on first shift with only 37.82 staffing hours provided and short on second shift with only 39.19 staffing hours

Review of the CDDR dated 08/06/16 revealed the census was 53, requiring 53 hours of staff time on first and second shifts and 42.4 hours of staff time on third shift.

Review of the PDR dated 08/06/16 revealed the facility was short in staffing hours on all three shifts: only 37.83 staff hours were provided on first shift, 31 hours on second shift, and 38.1 hours on third shift.

Review of the CDDR dated 08/07/16 revealed the census was 54, requiring 54 hours of staff time on first and second shifts and 43.2 hours of staff

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time on third shift.

Review of the PDR dated 08/07/16 revealed the facility was short in staffing hours on all three shifts: only 30.83 staff hours were provided on first shift, 32.08 hours on second shift, and 38.52 hours on third shift.

Review of the CDDR dated 08/19/16 revealed the census was 53, requiring 52 hours of staff time on first and second shifts and 41.6 hours of staff time on third shift.

Review of the PDR dated 08/19/16 revealed the facility was short in staffing hours on first shift with only 45.98 staffing hours provided and short on second shift with only 41.9 staffing hours.

Review of the CDDR dated 08/20/16 revealed the census was 51, requiring 51 hours of staff hours on first and second shifts and 40.8 hours of staff time on third shift.

Review of the PDR dated 08/20/16 revealed the facility was short in staffing hours on first shift with only 38.2 staffing hours provided and short on second shift with only 31.75 staffing hours.

Review of the CDDR dated 8/21/16 revealed the census was 52, requiring 52 hours of staff time on first and second shifts and 41.6 hours of staff time on third shift.

Review of the PDR dated 08/21/16 revealed the facility was short in staffing hours on first shift with only 37.65 staffing hours provided and short on second shift with only 38.03 staffing hours

Review of the CDDR dated 08/22/16 revealed the census was 52, requiring 52 hours of staff time

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on first and second shifts and 41.6 hours of staff time on third shift.

Review of the PDR dated 08/22/16 revealed, the facility was short in staffing hours on first shift with only 34.45 staffing hours provided and short on second shift with only 41.53 staffing hours.

Review of the CDDR dated 09/03/16 revealed the census was 54, requiring 54 hours of staff time on first and second shifts and 43.2 hours of staff time on third shift.

Review of the PDR dated 09/03/16 revealed the facility was short in staffing hours on all three shifts: only 38.99 staff hours were provided on first shift, 31.5 hours on second shift, and 30.48 hours on third shift.

Review of the CDDR dated 09/04/16 revealed the census was 54, requiring 54 hours of staff time on first and second shifts and 43.2 hours of staff time on third shift.

Review of the PDR dated 09/04/16 revealed the facility was short in staffing hours on all three shifts: only 32 staff hours were provided on first shift, 36 hours on second shift, and 28.83 hours on third shift.

Review of the CDDR dated 09/05/16 revealed the census was 54, requiring 54 hours of staff time on first and second shifts and 43.2. hours of staff time on third shift.

Review of the PDR dated 09/05/16 revealed the staffing requirement was met on all three shifts.

Confidential staff interview revealed:
The MCM told staff that corporate made the

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schedule.
-There were times when there was not enough staff working, but staff made sure the residents were dry and bathed who they could.
-"We do the best we can."
-The staff did not know what the staffing ratio should be because the ED and MCM would not tell the staff.
-The ED and MCM allowed staff to work overtime and asked staff to pick up extra shifts.
-When staff called out, other staff were called in, but sometimes the staff would not come in to work because they worked so many days that they needed a day off.

Confidential interview with a second staff revealed:
-The facility was short staffed "all the time."
-Sometimes there was not even one personal care aide (PCA) scheduled for each of the three halls.
-There had been times when residents' personal care was "lacking" due to short staffing.
-The MCM told staff to "do what you can."
-Staff documented personal care in the computer.

Confidential interview with a third staff revealed:
-There were times when the facility was short staffed.
-The short staffing had been "going on a while."
-Sometimes there was only one MA and 2 PCAs on an entire shift.
-The ED and MCM were aware of the short staffing problem.
-Families had "not really complained" but had said there was not enough staff.

Confidential interview with a fourth staff revealed:
-There were supposed to be 5 PCAs and 1 MA scheduled and on duty on third shift.

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-The facility was short staffed "a majority of the time."
-There had been times on third shift when there were only two or three staff in the building.
-The staff were told by the ED to "do the best we could."
-"What if there was an emergency? What would we do? "

Confidential interview with a fifth staff revealed:
-Most of the time, there were only 4 or 5 staff working on each shift.
-When staff called out, some staff could not stay over to work a double shift because they had other obligations.
-The MCM would not come out to the floor to help residents or other staff.
-Residents do not get the help they need because there was not enough staff.

Confidential interview with a sixth staff revealed third shift was short staffed at times and some tasks were not done for the residents.

Confidential interview with a seventh staff revealed:
-Second shift was short "often."
-Staff kept quitting so there was not enough staff to work.
-The residents were the ones who suffered from the short staffing.

Interview with a resident on 09/13/16 at 9:30 a.m. revealed a staff member on 3rd shift told him they were short staffed on 09/12/16.

Interview with a second resident on 09/13/16 at 2:38 p.m. revealed:
-The resident did not receive a bath that day (09/13/16) and did not know why, maybe because

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there was not enough workers.
-Staff do not show up for work sometime.

Confidential telephone interview with a resident's family member revealed:
-The family member did not know if the facility was short staffed or how many staff were working when the family visited.
-The family member was told the facility had 8 staff members on the floor at all times and one was a Medication Aide (MA).

Confidential telephone interview with a second family member revealed:
-The family recalled there were times when the family visited the resident, and the resident had not been bathed on shaved, especially on weekends. .
-The family did not know how many people were supposed to be scheduled or if the facility was short staffed.
-The family observed there were usually 4 or 5 staff working and there was a staff member "assigned" to take care of the resident "most of the time."

Confidential interview with a third family member revealed:
-Sometimes when the family visited it was "hard to find" staff.
-There was not enough staff on duty sometimes for the resident to receive a shower.
-The residents' laundry was not kept up to date.

Interview with the MCM on 09/09/16 at 1:28pm revealed:
-The facility had been short staffed for two months.
-There were supposed to be 7 or 8 staff working on each shift.

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-The resident to staff ratio was supposed to be 1:8.
-Staff did not show up for work or called out.
-Staff "often" did not notify her when staff were out.

Interview with the MCM on 09/13/16 at 4:35pm revealed:
-The were instances when "there is not enough staff."
-Staff called out or did not show up to work "all the time."

Interview with the Executive Director (ED) on 09/09/16 at 07:30am revealed:
-First shift should be staffed with 7-8 staff members consisting of two Medication Aides (MAs) and five Personal Care Aides (PCAs).
-Second shift should be staffed with 7 staff members consisting of two MAs and five PCAs.
-Third shift should be staffed with 5 or 6 staff members consisting of one or two MAs and four or five PCAs; "we try to have 6 (staff) on third."
-The MCM would be able to answer staffing and scheduling questions better than the ED.

Interview with the ED on 09/14/16 at 12:25pm revealed:
-The MCM was responsible for scheduling and staffing.
-The MCM had notified the ED the facility was short staffed.
-Within the last month, the ED had received complaints from residents' families about the facility's lack of staff.
-The ED had been notified by 3rd shift staff on the weekends that 3rd shift was short staffed because staff had called out; there were only 3 or 4 staff working on 3rd shift (unsure of the date).
-The facility had tried to hire more staff; a "big

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D 465	Continued From page 117 group" of staff were hired last month. -Some staff had quit without working a notice. Review of the Plan of Protection submitted by the facility dated 09/13/16 revealed: -The facility would immediately review staffing for all shifts to assure shifts were staffed according to the state guideline requirements. -The MCM and ED would review the schedule for adequate coverage. -Staff scheduled would not leave the facility until the end of their scheduled shift, until management had relieved them of their shift. -Management would be in the facility daily including weekends to assure adequate staffing. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2016.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the	D 468		

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	HAL051041	A. BUILDING: _____ B. WING _____	C 09/14/2016

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CLAYTON HOUSE	145 DAIRY ROAD CLAYTON, NC 27520

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D 468	Continued From page 118 special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 6 staff sampled (Staff A and Staff F) received 6 hours of training on the nature and needs of residents residing in a special care unit within one week of employment and 20 hours of training within six months of employment on the nature and needs of residents in a special care unit. The findings are: Review of the facility's current license revealed the facility was licensed as a special care unit (SCU). 1. Review of Staff A's personnel record revealed: -Staff A was hired on 10/23/13 as a Personal Care Aide (PCA). -There was no documentation of the required 6 hour training being completed within one week of hire. -There was no documentation of the required 20	D 468		

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D 468	Continued From page 119	D 468		

hour training being completed within six months of hire.
-There was documentation of training completed as follows: 1 hour on 04/11/14; 2 hours on 04/15/14.
-There was no documentation of additional training in 2015 and 2016.

Staff A was not available for interview.

Interview with the Executive Director (ED) on 09/07/16 at 5:16pm revealed Staff A was out on leave.

Refer to the interview with the Business Office Manager (BOM) on 09/13/16 at 2:30pm.

Refer to the interview with the ED on 09/13/16 at 3:05pm.

2. Review of Staff F's personnel record revealed:
-Staff F was hired 11/12/14 as a PCA.
-Staff F was terminated 11/18/15.
-There was no documentation of the required 6 hour training being completed within one week of hire.
-There was no documentation of the required 20 hour training being completed within six months of hire.
-There was documentation of only two hours of training dated 05/27/15 and 06/18/15.
-There was no other documentation of training found in Staff F's personnel record.

Staff F was not available for interview due the termination.

Refer to the interview with the BOM on 09/13/16 at 2:30pm.

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D 468	Continued From page 120 Refer to the interview with the ED on 09/13/16 at 3:05pm. _____ Interview with the BOM on 09/13/16 at 2:30pm revealed the BOM was responsible for staff qualifications and personnel files. Interview with the ED on 09/13/16 at 3:05pm revealed the BOM was responsible for staff qualifications.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received the care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to housekeeping and furnishings, nutrition and food service, staffing, and reporting accidents and incidents. The findings are: 1. Based on interviews and record reviews, the facility failed to assure the minimum staffing requirements were maintained to meet the needs of the residents in the special care unit (SCU) for	D912		

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D912	Continued From page 121 32 of 42 shifts sampled from 08/01/16-08/07/16, 08/19/16-08/22/16, and 09/03/16-09/05/16. [Refer to Tag D465, 10A NCAC 13F. 1308 (a)Special Care Unit Staffing (Type B Violation)]. 2.Based on observations and interviews, the facility failed to assure the walls, floors and ceilings in resident rooms, shared bathrooms, hallways, dining room, kitchen, and the kitchen's pantry were kept in good repair including peeling, detached, missing, and dangling ceiling covering, detached baseboards, missing or peeling paint, scuffed areas, cracks, open holes and creviced areas that could possibly serve as an entry point and harbor for pests. [Refer to Tag D74, 10A NCAC 13F. 0306 (a)(1) Housekeeping and Furnishings (Type B Violation)]. 3. Based on observations and interviews, the facility failed to maintain an environment free of hazards and obstructions as evidenced by failing to repair an uncovered electrical outlet beside a resident's bed who was oxygen dependent, resulting in the oxygen machine being plugged in to an electrical outlet in the common 200 hallway, creating a trip/fall hazard; failing to enclose an electrical outlet and light switch left in an unoccupied empty resident room (#209); failing to enclose electrical wiring approximately 6 feet high on the wall next to the entrance door in the activity room; and storing 4 unused televisions on the floor in the television room on the 300 hall. [Refer to Tag D79, 10A NCAC 13F. 0306 (a)(5) Housekeeping and Furnishings (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure the food preparation, storage and serving areas for the facility were free from contamination related to an	D912		

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D912	Continued From page 122 infestation of roaches. [Refer to Tag D282, 10A NCAC 13F. 0904 (a) Nutrition and Food Service (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to notify the physician and implement additional supervision and/or safety interventions to prevent residents from harm from a resident (#3) who was known not to like other residents in or near his room and had a history of pushing another resident (#4) on multiple occasions who wandered into his room. [Refer to Tag D282, 10A NCAC 13F. 1212 (g) Reporting of Accidents and Incidents (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure all residents were free of physical harm and neglect. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 1 of 2 residents sampled (#4) who had a history of wandering in to other residents' rooms was protected from physical harm by another resident (#3) who was known not to like wandering residents in his room resulting in Resident #4 sustaining a hip fracture after being pushed by Resident #4; to investigate a families member's concerns for one resident (#4) with injuries of	D914		

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D914	Continued From page 123 unknown origin such as scratches, bruises, and a knot on the head; to follow their established protocol for 2 of 2 residents sampled when bed bug activity was confirmed in one resident's room (#8) and bed bug bites were found on another resident (#11) to include notifying their contracted pest control provider of bed bug activity and training all staff on the established protocol to follow for bed bug activity. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A1 Violation)].	D914		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the	D992		

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D992	Continued From page 124 physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure complete screening and examination for the presence of controlled substances was performed for 1 of 6 staff sampled (Staff A) hired after 10/01/13. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 10/23/13. -There was documentation of a drug screen performed on 09/28/15; no results were documented on the form. -There were no other drug screenings in Staff A's personnel file. Interview with the Executive Director (ED) on 09/07/16 at 5:16pm revealed Staff A was out on leave during the survey. Interview with the Business Office Manager (BOM) on 09/13/16 at 2:30pm revealed the BOM was responsible for staff qualifications and personnel files.	D992		

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D992	Continued From page 125 Interview with the BOM on 09/13/16 at 3:00pm revealed upon review of the drug screen form in Staff A's personnel record dated 09/18/15, the BOM acknowledged there were no results doucmented. Staff A was not available for interview. Interview with the ED on 09/13/16 at 3:05pm revealed the BOM was responsible for staff qualifications and drug screening.	D992		